March 15, 2001

TO: All Interested Parties

RE: HCFA Legislative Summary -- March 2001

Attached are HCFA Legislative summaries for the following:

-- H.R. 5661, Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act

of 2000, P. L. 106-554, Omnibus Consolidated and Emergency Supplemental Appropriations for FY 2001, Signed 12/21/00

-- Medicaid Related Provisions of H. R. 4386, Breast and Cervical Cancer Prevention and Treatment Act of 2000, P. L. 106-354, Signed 10/24/00

-- Medicaid Related Provisions of H. R. 4365, Children's Health Act of 2000, P. L. 106-310, Signed 10/17/00

-- Medicare and Medicaid Related Provisions of S. 406, Alaska Native and American Indian Direct Reimbursement Act of 2000, P. L. 106-417, Signed 11/1/00

-- Medicare Related Provision of H. R. 2498, Public Health Infrastructure Improvement Act of 2000, P. L. 106-505, Signed 11/13/00

-- Medicare Related Provisions of H. R. 4205, Floyd D. Spence National Defense Authorization Act for FY 2001, P. L. 106-398, Signed 10/30/00

Don Johnson

Acting Director

Office of Legislation

Attachments

SUMMARY of:

H.R. 5661, Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, P. L. 106-554, Omnibus Consolidated and Emergency Supplemental Appropriations for FY 2001, Signed 12/21/00

and

Medicaid Related Provisions of H. R. 4386, Breast and Cervical Cancer Prevention and Treatment Act of 2000, P. L. 106-354, Signed 10/24/00

Medicaid Related Provisions of H. R. 4365, Children's Health Act of 2000, P. L. 106-310, Signed 10/17/00

Medicare and Medicaid Related Provisions of S. 406, Alaska Native and American Indian Direct Reimbursement Act of 2000, P. L. 106-417, Signed 11/1/00

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Medicare Related Provisions of H. R. 4205, Floyd D. Spence National Defense Authorization Act for FY 2001, P. L. 106-398, Signed 10/30/00

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TITLE I -- MEDICARE BENEFICIARY IMPROVEMENTS

Subtitle A -- Improved Preventive Benefits

Coverage of Biennial Screening Pap Smear and Pelvic Exams (Section 101)

Prior Law:

- Screening Pap smears and pelvic exams (including a clinical breast exam) are covered every 3 years, or annually for women of childbearing age who have had an abnormal Pap smear during the preceding 3 years, or women at high risk for cervical or vaginal cancer. There is no beneficiary cost-sharing for clinical laboratory tests (including Pap smears). Application of the Part B deductible is waived for other aspects of the benefit.

Provision:

- The provision increases the current periodicity of general coverage of Pap smears and pelvic exams by providing for coverage every 2 years.

Effective Date:

- July 1, 2001.

Coverage of Screening for Glaucoma (Section 102)

Prior Law:

- Glaucoma evaluation procedures are covered only for diagnostic purposes, for

individuals with signs or symptoms indicating the possible presence of glaucoma.

Provision:

- The provision authorizes annual coverage of glaucoma screening for individuals at high risk for glaucoma, individuals with a family history of glaucoma, and individuals with diabetes.

- Covered services include a dilated eye exam with an intraocular pressure measurement, and a direct ophthalmoscopy or slit-lamp biomicroscopic exam for the early detection of glaucoma. Services must be furnished by, or under the direct supervision of, an optometrist or ophthalmologist who is legally authorized to perform such services in the State where the services are furnished.

Effective Date:

- January 1, 2002.

Coverage of Screening Colonoscopy for Average Risk Individuals (Section 103)

Prior Law:

- Colorectal cancer screening procedures are covered as follows: (1) fecal-occult blood tests for persons age 50 and over are covered annually, (2) flexible sigmoidoscopy for persons age 50 and over are covered every 4 years, (3) colonoscopy for persons at high risk for colorectal cancer are covered every 2 years, and (4) other procedures are covered as the Secretary finds appropriate. Barium enemas are also covered as a substitute for a flexible sigmoidoscopy or a colonoscopy.

Provision:

- The provision authorizes coverage of screening colonoscopies for all individuals, not just those at high risk. For persons not at high risk, a screening colonoscopy is covered 10 years after a previous screening colonoscopy or 4 years after a screening flexible sigmoidoscopy.

Effective Date:

- July 1, 2001.

Modernization of Screening Mammography Benefit (Section 104)

Prior Law:

- Screening mammograms are covered annually for all women age 40 and over, and one baseline mammogram is covered for women age 35-39. Application of the Part B deductible is waived for screening mammography. Medicare pays the lowest of: (1) the actual charge, (2) the physician fee schedule amount, or (3) a national limit set by statute ($55 in 1991, updated annually by the Medicare Economic Index).

Provision:

- The provision moves payment for screening mammography to the physician fee schedule (the same payment method used for diagnostic mammography), thereby eliminating the statutory payment limit set by the prior law.

- The provision specifies payment rates for 2 new forms of mammography that utilize digital technology for services furnished April 1, 2001 through December 31, 2001 (applicable to both screening and diagnostic mammograms). Payment for technologies that directly take digital images is set at 150 percent of payment for a bilateral diagnostic mammogram under the physician fee schedule. Payment for technologies that convert standard film images to digital form is set at the statutory limit for a screening mammogram for 2001, plus $15.

- The Secretary must determine whether a new HCPCS code is required for new technology mammograms furnished after 2001.

Effective Date:

- Payment for screening mammography under the physician fee schedule is effective January 1, 2002. The specified payment rates for mammography utilizing digital technology begin April 1, 2001, and end December 31, 2001.

Coverage of Medical Nutrition Therapy Services for Beneficiaries with Diabetes or a Renal Disease (Section 105)

Prior Law:

- Medical nutrition therapy services are not covered as a preventive benefit or as a distinct treatment modality under Medicare. Such services are covered as a component of outpatient diabetes self-management training, and may be provided by a hospital, skilled nursing facility, dialysis facility, hospice, or home health agency as part of a bundle of services such entities provide to their patients. "Medically necessary" nutrition counseling may also occur as part of a physician office exam or "incident to" a physician's services. Enteral and parenteral nutrition is covered to a limited degree under the prosthetic device benefit.

Provision:

- The provision authorizes Medicare coverage of medical nutrition therapy services for beneficiaries who have diabetes or a renal disease. The benefit is limited to beneficiaries who: (1) have not received diabetes outpatient self-management training within a designated time period (to be determined by the Secretary), (2) are not receiving maintenance dialysis paid for by Medicare, and (3) meet other eligibility criteria established by the Secretary, in consultation with professional groups.

- Medical nutrition therapy services are defined as nutritional diagnostic, therapy and counseling services for the purpose of disease management, which are furnished by a registered dietician or nutrition professional, pursuant to a physician's referral.

- Payment for such services equals 80 percent of the lesser of the actual charge or 85 percent of the payment that would be made under the physician fee schedule. Assignment is required for all claims. Sanctions may be applied for billing violations.

- The Secretary must submit a report to Congress by July 1, 2003, with recommendations for expansion of the benefit to other beneficiary populations.

Effective Date:

- Coverage of medical nutrition therapy services is effective January 1, 2002.

Subtitle B -- Other Beneficiary Improvements

Acceleration of Reduction of Beneficiary Copayment for Hospital Outpatient Department Services (Section 111)

Prior Law:

- Medicare payments to hospitals for outpatient department services increase annually while beneficiary copayments for those services are frozen until they reach 20 percent of the total payment to hospitals. HCFA projects that the average national copayment will be 20 percent of payments by 2029.

- Copayments for each ambulatory payment classification (APC) are limited to the inpatient hospital deductible for the year.

- Hospitals may elect to reduce the copayment for an APC for a year to not less than 20 percent of the total payment amount. This election must occur prior to the beginning of the year and cannot be changed over the course of the year.

Provision:

- The provision caps the effective coinsurance rate (the percentage of the total payment paid by the beneficiary) for each APC at a specified percentage:

-- In 2001 (for services received after April 1), 57 percent;

-- in 2002 and 2003, 55 percent;

-- in 2004, 50 percent;

-- in 2005, 45 percent;

-- in 2006 and thereafter, 40 percent.

- Hospitals are given broad authority to waive any portion of the PPS copayment that represents an increase in cost-sharing from the previous system.

- GAO is to conduct a study with the National Association of Insurance Commissioners on the extent to which these reductions are reflected in Medigap premium levels. The report is due April 1, 2004.

Effective Date:

- Services furnished on or after April 1, 2001.

Preservation of Coverage of Drugs and Biologicals under Part B of the Medicare Program (Section 112)

Prior Law:

- Current law provides for coverage of certain drugs and biologicals when they are administered "incident to" a physician's services in a physician's office or hospital outpatient setting and "cannot, as determined in accordance with regulations, be self-administered." No regulations address "self-administered."

Provision:

- This provision provides coverage for drugs and biologicals that "are not usually self-administered by the patient."

Effective Date:

- Upon enactment.

Elimination of the Time Limitation on Medicare Benefits for Immunosuppressive Drugs (Section 113)

Prior Law:

- Prior to the Balanced Budget Refinement Act of 1999 (BBRA), beneficiaries were entitled to coverage for immunosuppressive drugs for 36 months after receiving a covered transplant. The BBRA increased the number of months of coverage by 8 months for beneficiaries who exhausted their coverage in 2000. For beneficiaries who exhausted the 36 month period in 2001, the BBRA provided for a minimum of 8 months of additional coverage. For beneficiaries who exhausted the 36 month period in 2002, 2003 and 2004, the Secretary was to specify the additional months of coverage in the preceding year. The cost of additional coverage available from 2001 to 2004 was limited to $150 million.

Provision:

- This provision removes all time and budget limitations on the benefit under part B, making coverage of immunosuppressive drugs a permanent benefit.

Effective Date:

- Upon enactment.

Imposition of Billing Limits on Drugs (Section 114)

Prior Law:

- Current law allows physicians and suppliers who furnish currently covered Medicare drugs to accept, or decline to accept, assignment. In addition, current law does not limit the amount that may be charged on unassigned claims for drugs and biologicals furnished, except for antigens and "incident to" drugs.

Provision:

- The provision requires that assignment be accepted for all currently-covered drugs and biologicals. It also applies to drugs and biologicals the same rules that apply to

  practitioners regarding penalties for charging more than the Medicare payment amount.

Effective Date:

- Drugs and biologicals furnished on or after January 1, 2001.

Waiver of 24-Month Waiting Period for Medicare Coverage of Individuals Disabled with Amyotrophic Lateral Sclerosis (ALS) (Section 115)

Prior Law:

- Disabled individuals who are entitled to Social Security Disability Insurance benefits must wait 24 months before becoming entitled to Medicare benefits.

Provision:

- This provision waives the 24-month waiting period for Medicare coverage for those individuals with ALS. The entitlement to Medicare begins with the first month of the Social Security Administration's determination of eligibility for Disability Insurance benefits. The initial enrollment period for Medicare begins on the first day of the first month the individual becomes eligible for Medicare.

Effective Date:

- Effective for benefits for months beginning July 1, 2001.

Subtitle C -- Demonstration Projects and Studies

Demonstration Project for Disease Management for Severely Chronically Ill Medicare Beneficiaries (Section 121)

Prior Law:

- The Secretary has general authority to test new payment systems or services that would improve the efficiency of the Medicare program.

- The BBA gave the Secretary the authority to conduct a coordinated care demonstration project to evaluate whether case management or other methods of coordinating care improve the quality of items and services provided to target beneficiaries and reduce Medicare expenditures. The demonstration is targeted at chronically-ill beneficiaries (as

defined by the Secretary) and is to be implemented at 5 urban and 3 rural sites and 1 site in the District of Columbia. Following an evaluation of the demonstration, the Secretary was given discretion to implement the beneficial portions of the project on a permanent basis.

Provision:

- The provision directs the Secretary to conduct a demonstration for up to 3 years on the impact on costs and health outcomes of disease management for beneficiaries diagnosed with certain chronic health conditions: advanced-stage congestive heart failure, diabetes, or coronary heart disease. Beneficiary enrollment is voluntary and capped at 30,000.

- The demonstration is to provide disease management services for the chronic health condition and coverage for all prescription drugs, regardless of whether or not they relate to the chronic health condition. Modest cost-sharing is allowed for the drugs.

- Participating disease management organizations must show that they can produce improved health outcomes and provide a net reduction in aggregate Medicare expenditures. The demonstration is limited to 3 disease management organizations.

- The Secretary must submit an interim report to Congress on the demonstration within 2 years of implementation and a final report within 6 months of its completion.

- In the case of enrollment or termination of enrollment, demonstration enrollees receive the same Medigap protections as Medicare+Choice enrollees.

Effective Date:

- Upon enactment.

Cancer Prevention and Treatment Demonstration for Ethnic and Racial Minorities (Section 122)

Prior Law:

- Eighteen Medicare Peer Review Organizations (PROs) are conducting 3-year projects to reduce disparities in breast cancer screening (mammography) for African Americans, Hispanics, and low-income beneficiaries who are dually eligible for Medicare and Medicaid.

Provision:

- The Secretary is directed to conduct at least 9 demonstration projects to develop models and to evaluate methods to: (1) improve the quality of services provided to Medicare beneficiaries who are racial and ethnic minorities, in order to facilitate reduced disparities in early detection and treatment of cancer; (2) improve clinical outcomes, satisfaction, quality of life, and appropriate referral and utilization of Medicare-covered services for target individuals with cancer; (3) eliminate disparities in the rate of cancer screening services among target individuals; and (4) promote collaboration with community-based groups to ensure cultural competency by health professionals and language access for

persons with limited English proficiency.

- "Target individuals" include members of racial and ethnic minority groups (as defined by section 1707 of the Public Health Service Act), who are enrolled under both Medicare Parts A and B. Two demonstrations are to be focused on each of the following groups: American Indians, Asian Americans and Pacific Islanders, Blacks and Hispanics. Other projects must also be focused on sub-populations in each of the following areas: the Pacific Islands, a rural area, and an inner-city area.

- Within 1 year of enactment, the Secretary is directed to evaluate best practices in the private sector, community programs, and academic research of methods that reduce disparities in cancer prevention and treatment among racial and ethnic minority groups. This evaluation will serve as the basis for the demonstration projects, which are to begin not later than 2 years after the enactment of BIPA.

- Not later than 2 years after the first demonstration begins, and biannually thereafter, the Secretary is required to report to Congress on the cost-effectiveness of the demonstration projects, the quality of services they provide, and beneficiary and provider satisfaction under the projects.

- If the projects reduce expenditures or do not increase expenditures while reducing disparities and increasing satisfaction, the Secretary is required to continue them and is authorized to expand the number of projects.

- Payments under the projects may not exceed amounts that would have been paid for cancer prevention and treatment without the projects, plus $25 million. Funding for projects in the States is directly appropriated in the Act, while funding for projects in the territories must come from the appropriation for the territories.

Effective Date:

- As noted above.

Study on Medicare Coverage of Routine Thyroid Screening (Section 123)

Prior Law:

- Routine thyroid screening is not covered by Medicare.

Provision:

- The provision directs the Secretary to request the National Academy of Sciences, in conjunction with the U.S. Preventive Services Task Force, to conduct a study on the addition of a new preventive benefit for coverage of routine thyroid screening, using a thyroid stimulating hormone test for some or all Medicare beneficiaries. The Secretary must report to Congress on the study's findings, including the long- and short-term benefits and costs to the Medicare program.

Effective Date:

- The report to Congress is due no later than 2 years after enactment.

MedPAC Study on Consumer Coalitions (Section 124)

Prior Law:

- No provision.

Provision:

- MedPAC is required to study the use of consumer coalitions in marketing Medicare+Choice plans. A consumer coalition is a non-profit community-based organization that informs beneficiaries of their health options under Medicare. These coalitions also negotiate with Medicare+Choice plans and other specified entities on benefits and premiums for beneficiaries who are coalition members and affiliates.

- The study must examine the potential for increased efficiency in Medicare through beneficiary knowledge, the implications of Medicare+Choice plans and Medicare supplemental policies offering beneficiaries in the same geographic location, different benefits and premiums based on coalition affiliation, the governance of coalitions, accountability of coalitions to the Secretary, and avoidance of coalition conflicts of interest.

Effective Date:

- The report to Congress is due within 1 year.

Study on Limitation on State Payment for Medicare Cost-Sharing Affecting Access to Services for Qualified Medicare Beneficiaries (Section 125)

Prior Law:

- States must pay Medicare deductibles and coinsurance on behalf of Medicare beneficiaries with incomes below poverty. The Balanced Budget Act of 1997 clarified that States have the authority to pay these amounts based on Medicaid rates for the same service, or they may pay based on the full Medicare rate.

Provision:

- The Secretary must conduct a study and report to Congress on the effects of the BBA provision on access to services by qualified Medicare beneficiaries.

Effective Date:

- The report to Congress is due no later than 1 year after enactment.

Studies on Preventive Interventions in Primary Care for Older Americans (Section 126)

Prior Law:

- The studies conducted by the U.S. Preventive Services Task Force are not focused on any

particular sub-populations or age groups.

Provision:

- The provision directs the Secretary, acting through the U.S. Preventive Services Task Force, to conduct a series of studies to identify preventive interventions that can be delivered in primary care settings, and that are most valuable to older Americans.

- The mission statement of the U.S. Preventive Services Task Force is amended to include the evaluation of services of particular relevance to older Americans.

- Not later than 1 year after enactment, and annually thereafter, the Secretary must report to Congress on the conclusions of the Task Force's studies, along with recommendations for legislation and administrative actions, as appropriate.

Effective Date:

- Reports are due as noted above.

MEDPAC Study and Report on Medicare Coverage of Cardiac and Pulmonary Rehabilitation Therapy Services (Section 127)

Prior Law:

- No provision.

Provision:

- The Medicare Payment Advisory Commission must conduct a study on the coverage of cardiac and pulmonary rehabilitation therapy services under the Medicare program. In conducting the study, the Commission is to focus on the appropriate:

    -- qualifying diagnoses required for coverage of cardiac and pulmonary rehabilitation therapy services;

    -- level of physician direct involvement and supervision in furnishing such services; and

    -- level of reimbursement for such services.

Effective Date:

- The report to Congress is due within 18 months, with recommendations for legislation and administrative actions.

Lifestyle Modification Program Demonstration (Section 128)

Prior Law:

- The Lifestyle Modification Program demonstration, which is directed at beneficiaries with cardiovascular disease, began on October 1, 1999, under HCFA's general

demonstration authority. The project allows a 3-year enrollment period ending on October 1, 2002, with payment for services through September 30, 2003 (a total of 4 years). Eligibility requirements for the demonstration were last modified effective November 29, 2000, at which time a request was made to extend the demonstration for an additional year. An evaluation of the demonstration is due 15 months after the end of the period during which payment for services is made.

Provision:

- The provision codifies the existing Lifestyle Modification Program demonstration by directing the Secretary to conduct the demonstration as described in a Memorandum of Understanding between HCFA and the entities that administer the programs. The treatment period is authorized to last 4 years (beginning November 13, 2000).

- The Secretary must determine whether the program is cost-effective by considering whether expenditures for beneficiaries enrolled in the program exceed expenditures for a non-enrolled control group with similar health conditions. The Secretary must submit an initial report to Congress not later than 1 year after the date on which 900 beneficiaries have completed the treatment program, and a final report by 1 year after the date on which 1,800 beneficiaries have completed the treatment program.

Effective Date:

- The demonstration project is already underway.

TITLE II -- RURAL HEALTH CARE IMPROVEMENTS

Subtitle A -- Critical Access Hospital Provisions

Clarification of No Beneficiary Cost-Sharing for Clinical Diagnostic Laboratory Tests Furnished by Critical Access Hospitals (Section 201)

Prior Law:

- The BBRA eliminates coinsurance and deductibles for outpatient clinical laboratory services furnished by critical access hospitals (CAHs), and establishes payment for these services based on the laboratory fee schedule.

Provision:

- This provision specifies that reimbursement for outpatient clinical diagnostic laboratory services provided by CAHs are based on reasonable costs and that Medicare beneficiaries are not liable for any cost-sharing amount for these services.

Effective Date:

- Effective as if enacted in the BBRA.

Assistance with Fee Schedule Payment for Professional Services Under All-Inclusive Rate (Section 202)

Prior Law:

- The BBRA allows CAHs to be paid for outpatient services based on reasonable costs or, at the election of the hospital, to be paid based on an all-inclusive rate that covers both facility and professional services. Professional fees are subject to the physician fee schedule.

Provision:

- This provision allows CAHs that elect the all-inclusive rate to now be paid a facility fee based on reasonable costs plus an amount based on 115 percent of the physician fee schedule for professional services.

Effective Date:

- Effective for items and services furnished on or after July 1, 2001.

Exemption of Critical Access Hospital Swing Beds from the Skilled Nursing Facility Prospective Payment System (Section 203)

Prior Law:

- The BBA requires the Secretary to develop an appropriate manner to apply SNF PPS to hospitals and CAHs with swing beds, after the SNF PPS transition period, which ends in 2002. Swing bed services are currently paid on a reasonable cost basis, subject to limits.

Provision:

- Swing beds in CAHs are exempt from the SNF PPS, and are paid for covered SNF services on a reasonable cost basis.

Effective Date:

- Effective for cost reporting periods beginning on or after the date of enactment.

Payment in Critical Access Hospitals for Emergency Room On-Call Physicians (Section 204)

Prior Law:

- No provision.

Provision:

- This provision requires the Secretary to recognize as reasonable costs amounts for the compensation and related costs for on-call emergency room physicians who are not present on the critical access hospital premises, are not otherwise furnishing services, and are not on call at any other provider or facility.

Effective Date:

- Effective for cost reporting periods beginning on or after October 1, 2001.

Treatment of Ambulance Services Furnished by Certain Critical Access Hospitals (Section 205)

Prior Law:

- Payment for ambulance services provided by critical access hospitals is based on the hospitals' reported "reasonable costs." The BBA mandated the replacement of the "reasonable cost" methodology with a national fee schedule for ambulance services.

Provision:

- The provision exempts ambulance services furnished by certain critical access hospitals, or by an entity owned and operated by a critical access hospital, from the ambulance fee schedule established by the BBA. The exemption only applies to a critical access hospital or entity that is the only provider or supplier of ambulance services within a 35-mile drive of the critical access hospital. These services will continue to be paid under the "reasonable cost" methodology.

Effective Date:

- Applies to services furnished on or after the date of enactment.

GAO Study on Certain Eligibility Requirements for Critical Access Hospitals (Section 206)

Prior Law:

- No provision.

Provision:

- This provision requires the GAO to conduct a study on the eligibility requirements for CAHs regarding limitations on the average length of stay and number of beds. As part of the study, the GAO is to analyze the feasibility of having a distinct part psychiatric or rehabilitation unit as part of a CAH. The GAO is also required to analyze the effect of seasonal variations in patient admissions on CAH eligibility requirements with respect to limits on the average annual length of stay and number of beds. In the report to Congress, the GAO is also to make recommendations on whether distinct part units should be permitted as part of a CAH; the payment methodologies for any such distinct part units; whether distinct part units should be included in the CAH bed limits; and any adjustments to eligibility to account for seasonal variations in patient admissions.

Effective Date:

- The report is due within 1 year after enactment.

Subtitle B -- Other Rural Hospitals Provisions

Equitable Treatment for Rural Disproportionate Share Hospitals (Section 211)

Prior Law:

- Urban and rural hospitals have different qualifying threshold amounts (which result from the statutory formula), described as "qualifying DSH percentages," in order to receive DSH payments. The following table describes the different thresholds and the corresponding adjustment computation for DSH payments:

Urban Hospitals	**Qualifying DSH Percentages (DSH pct.)**	**Adjustment Computation**
0-99 Beds	>40%	5%
100+ Beds	15%≥20.2% >20.2%	2.5% + [.65 x (DSH pct.-15%)] 5.88% + [.825 x (DSH pct.-20.2%)]
Rural Hospitals		
Sole Community Hospitals (SCH)	>30%	10%
Rural Referral Centers (RRC)	>30%	4% + [.6 x (DSH pct.-30%)]
Both SCH and RRC	>30%	higher of SCH or RRC adjustment
Other Rural Hospitals		
0-99 Beds	>45%	4.0%
100-499 Beds	>30%	4.0%
500+ Beds	15%≥20.2% >20.2%	2.5% + [.65 x (DSH pct.-15%)] 5.88% + [.825 x (DSH pct. -20.2%)]

Provision:

- This provision allows all hospitals to be eligible to receive DSH payments when their

DSH percentage (threshold amount) exceeds 15 percent. The DSH payment formulas for sole community hospitals (SCHs), rural referral centers (RRCs), rural hospitals that are both SCHs and RRCs, small rural hospitals, and urban hospitals with less than 100 beds are modified to give these hospitals higher DSH payments. The following table describes the revised thresholds and adjustment computations:

Urban Hospitals	**Qualifying DSH Percentages (DSH pct.)**	**Adjustment Computation**
0-99 Beds	15%≥19.3% >19.3%	2.5% + [.65 x (DSH pct.-15%)] 5.25%
100+ Beds (No Change in Law)	15%≥20.2% >20.2%	2.5% + [.65 x (DSH pct.-15%)] 5.88% + [.825 x (DSH pct.-20.2%)]
Rural Hospitals		
Sole Community Hospitals (SCH)	15%≥19.3% 19.3%≥30% >30%	2.5% + [.65 x (DSH pct.-15%)] 5.25% 10%
Rural Referral Centers (RRC)	15%≥19.3% 19.3%≥30% >30%	2.5% + [.65 x (DSH pct.-15%)] 5.25% 5.25% + [.6 x (DSH pct.-30%)]
Both SCH and RRC	>15%	higher of SCH or RRC adjustment
Other Rural Hospitals		
0-499Beds	15%≥19.3% >19.3%	2.5% + [.65 x (DSH pct.-15%)] 5.25%
500+ Beds (No Change in Law)	15%≥20.2%	2.5% + [.65 x (DSH pct.-15%)]

	>20.2%	5.88% + [.825 x (DSH pct. -20.2%)]

Effective Date:

- Effective for discharges occurring on or after April 1, 2001.

Option to Base Eligibility For Medicare Dependent, Small Rural Hospital Program on Discharges During 2 of the 3 Most Recently Audited Cost Reporting Periods (Section 212)

Prior Law:

- Medicare Dependent Hospitals (MDHs) are small rural hospitals for which Medicare patients comprise a significant percentage of inpatient days or discharges. An MDH must have 100 or fewer beds, not be classified as a sole community hospital, and must have at least 60 percent of its inpatient days or discharges attributable to patients receiving Medicare Part A services for cost reporting periods during FY 1987.

Provision:

- This provision allows an otherwise qualifying hospital to be classified as an MDH if at least 60 percent of its days or discharges were attributable to Medicare Part A beneficiaries in at least 2 of its 3 most recently audited cost reporting periods.

Effective Date:

- For cost reporting periods beginning on or after April 1, 2001.

Extension of Option to Use Rebased Target Amounts to All Sole Community Hospitals (Section 213)

Prior Law:

- Before the BBRA, sole community hospitals (SCHs) received payments based on the largest of: (1) a hospital-specific target amount based on its updated FY 1982 costs; (2) a hospital-specific target amount based on its updated 1987 costs; or (3) the Federal national standardized amount.

- The BBRA permitted SCHs that were paid based on hospital-specific target amounts in 1999 to be paid a target amount based on their FY 1996 costs. A transition to the 1996 target amount was provided:

    -- For discharges during FY 2001, the hospital-specific rate will be the sum of 75 percent of the 1982 or 1987 rate plus 25 percent of the 1996 rate;

    -- For discharges during FY 2002, the hospital-specific rate will be the sum of 50 percent of the 1982 or 1987 rate plus 50 percent of the 1996 rate;

    -- For discharges during FY 2003, the hospital-specific rate will be the sum

of 25 percent of the 1982 or 1987 rate plus 75 percent of the 1996 rate;

-- For discharges during FY 2003 or any subsequent fiscal year, the applicable hospital-specific rate will be 100 percent of the 1996 amount.

Provision:

- This provision allows all SCHs to elect payment based on their hospital-specific FY 1996 costs if this target amount results in higher Medicare payments. The transition provided by the BBRA is still applicable.

Effective Date:

- Retroactive to the enactment of the BBRA, effective for cost reporting periods beginning on or after October 1, 2000.

MedPAC Analysis of Impact of Volume on Per Unit Cost of Rural Hospitals with Psychiatric Units (Section 214)

Prior Law:

- The BBRA requires the Medicare Payment Advisory Commission (MedPAC) to evaluate the special payments and payment methodologies established for rural hospitals, including their impact on beneficiary access and quality of services.

Provision:

- This provision requires MedPAC to include in its study an analysis of the impact of volume on the per-unit cost of rural hospitals with psychiatric units and to provide a recommendation on whether special treatment for such hospitals is warranted.

Effective Date:

- The report is due to Congress no later than 18 months after the date of enactment of the BBRA.

Subtitle C -- Other Rural Provisions

Assistance for Providers of Ambulance Services in Rural Areas (Section 221)

Prior Law:

- Pending implementation of a national ambulance fee schedule as required by the BBA, ambulance services are paid under “reasonable charge” and “reasonable cost” methodologies. Four billing methods are used, 2 of which allow separate payment for mileage and 2 of which include mileage in the base rate paid for the total ambulance service. Mileage rates do not distinguish between rural and urban settings.

- Under the new fee schedule, all mileage will be paid separately, rather than bundled into the base rate for some suppliers. Mileage rates will vary between ground, fixed-wing air, and rotary-wing air ambulances, and payment for some mileage in rural areas will be

made at a higher rate.

Provision:

- The provision provides a 2-1/2 year transitional increase in mileage rates for ground ambulance services with a point of pickup in a rural area, for trips over 17 miles and up to 50 miles. ("Rural area" is defined as a non-MSA or a rural census tract of an MSA under the most recent version of the Goldsmith modification). Payment is specified as the mileage rate otherwise established under the fee schedule, increased by not less than half of the additional payment per mile for the first 17 miles of a rural trip. For services beginning July 1, 2001 and before January 1, 2002, the rate increase will be $1.25 per mile.

- GAO is required to study, by June 30, 2002, rural ambulance services (including costs and means of identifying low-density/low-usage rural areas), and report to Congress with recommendations on steps that would assure ambulance access in rural areas. In providing for adjustments to the fee schedule for years beginning in 2004, the Secretary is required to consider the GAO's recommendations and adjust rates to reflect increased costs (if any) for services in low-density rural areas.

  (See Section 225, which calls for a MedPAC study on "low-volume, isolated rural health care providers.")

Effective Date:

- Transitional payment for rural ambulance trips over 17 miles and up to 50 miles applies July 1, 2001 through December 31, 2003.

Payment for Certain Physician Assistant Services (Section 222)

Prior Law:

- A physician assistant who owned a rural health clinic (RHC) prior to the enactment of the BBA that has since lost its designation as an RHC may bill Medicare directly for services provided before January 1, 2003.

Provision:

- This provision makes permanent the authority for physician assistants who owned rural health clinics that lost their RHC designation to bill Medicare directly.

Effective Date:

- Upon enactment.

Revision of Medicare Reimbursement for Telehealth Services (Section 223)

Prior Law:

- The BBA requires the Secretary to make Part B payments to a physician or practitioner

who furnishes professional consultations via a telecommunications systems. Professional consultations currently are the only eligible services allowable under telemedicine. Eligibility for telemedicine services is based on the beneficiary's place of residence, which must be in a rural county that is designated as a health professional shortage area (HPSA). Eligibility is not based on the designation of originating sites. Payment is shared between the consulting physician or practitioner and the telepresenter, and is subject to Medicare coinsurance and deductible requirements. Balance billing limits are applicable. Payment is not made for telephone line charges or facility fees. Payment for telehealth services is increased annually by the update factor for physicians' services under the fee schedule.

Provision:

- This provision expands the telemedicine benefit under Medicare by:

  -- requiring the Secretary to make payments to a physician or practitioner who furnishes a telehealth service at the distant site at the same amount that would have been paid if the service had been furnished without the use of a telecommunications system.

  -- removing the requirement for a telepresenter, unless the physician or provider deems it medically necessary to have a telepresenter with the beneficiary.

  -- designating professional consultations, office visits, and psychiatry office visits, in addition to services determined by the Secretary to be appropriate to be delivered via telemedicine, as eligible services.

  -- paying a facility fee of $20, updated after 2002, to the originating site where the beneficiary is located. Telehealth services and facility fees are subject to Medicare coinsurance and deductible requirements. Balance billing limits are applicable. Originating sites include a physician or practitioner's office, a critical access hospital, a rural health clinic, a Federally-qualified health center or a hospital.

  -- specifying that originating sites must be located in rural HPSAs or non-Metropolitan Statistical Areas (non-MSAs). Entities participating in Federal demonstration projects approved by, or receiving funding from, the Secretary as of December 31, 2000 also are eligible originating sites.

  -- requiring the Secretary to conduct a study and submit recommendations to Congress on additional settings, sites, practitioners and geographic areas that would be appropriate for telehealth services.

Effective Date:

- Effective for services furnished on or after October 1, 2001.

Expanding Access to Rural Health Clinics (Section 224)

Prior Law:

- Rural hospitals of less than 50 beds that own rural health clinics are exempt from the per visit limit applied to the RHC payment.

Provision:

- All hospitals of less than 50 beds that own rural health clinics will be exempt from the per visit limit.

Effective Date:

- Applies to services furnished on or after July 1, 2001.

MedPAC Study on Low-Volume, Isolated Rural Health Care Providers (Section 225)

Prior Law:

- No provision.

Provision:

- This provision requires MedPAC to study the effect of low patient and procedure volume on the financial status and Medicare payment methods for hospital outpatient services, ambulance services, hospital inpatient services, skilled nursing facility services, and home health services in isolated rural health care providers.

Effective Date:

- The report is due within 18 months of the date of enactment.

TITLE III -- PROVISIONS RELATING TO PART A

Subtitle A -- Inpatient Hospital Services

Revision of Acute Care Hospital Payment Update for 2001 (Section 301)

Prior Law:

- The BBA established an update of the market basket (MB) minus 1.1 percentage points for all PPS hospitals for FY 2001 and FY 2002, and for subsequent years, provided the full market basket percentage increase for all hospitals. The BBRA modified this provision to set the rate for sole community hospitals at the full market basket percentage increase for FY 2001.

Provision:

- The provision establishes a full market basket update for all PPS hospitals for FY 2001, an update of the MB minus 0.55 percentage points for FY 2002 and FY 2003, and a full market basket increase for FY 2004 and subsequent years.

- The provision requires the Secretary to consider the price of blood and blood products when rebasing and revising the hospital market basket index.

- The provision requires MedPAC to conduct a study on any increased hospital costs attributable to complying with new blood safety measures and providing services using new technology.

- The provision authorizes the Secretary to adjust the standardized amounts for case mix change to eliminate the effect of changes in the coding and classification of discharges that do not reflect real changes in the case mix.

Effective Date:

- The FY 2001 update provision is effective for discharges occurring on or after April 1, 2001 at MB plus 1.1 (thus providing an average update of the full MB for FY 2001).

- The provision requiring the Secretary to consider the price of blood and blood products is effective upon enactment.

- The MedPAC report is due no later than 1 year after the date of enactment.

- The Secretary's authority to adjust for case mix change is effective for discharges on or after October 1, 2001.

Modification in Transition for Indirect Medical Education (IME) Percentage Adjustments (Section 302)

Prior Law:

- The BBA reduced the Medicare IME add-on payment to 6.0 percent in FY 2000 and 5.5 percent beginning with FY 2001. The BBRA adjusted the schedule established in the BBA by setting the add-on payments at 6.5 percent for FY 2000, 6.25 percent for FY 2001 and 5.5 percent for FY 2002 and thereafter.

Provision:

- This provision modifies the IME adjustment schedule by maintaining 6.5 percent for FY 2001 and 2002, and by reducing the payment add-on to 5.5 percent beginning with FY 2003.

Effective Date:

- Effective for discharges occurring on or after April 1, 2000.

Decrease in Reduction for Disproportionate Share Hospital (DSH) Payments (Section 303)

Prior Law:

- The BBA reduced Medicare DSH payments by 4 percent in FY 2001 and by 5 percent in FY 2002. The BBRA lessened the BBA reduction of DSH payments so that the reduction

equaled 3 percent in FY 2001 and 4 percent in FY 2002.

Provision:

- This provision further lessens the reduction of DSH payments; the reduction equals 2 percent in FY 2001 (instead of 3 percent) and 3 percent in FY 2002 (instead of 4 percent).

Effective Date:

- Effective for discharges occurring on or after April 1, 2001, when the adjustment will be reduced by 1 percent, resulting in a total average reduction for the fiscal year of 2 percent.

Wage Index Improvements (Section 304)

Prior Law:

- For inpatient hospital PPS, hospitals may apply to the Medicare Geographic Classification Review Board (MGCRB) to be reclassified to a different geographic area than the one in which they are located for purposes of the standardized payment amount or the wage index. MGCRB decisions regarding hospital applications to reclassify to a different geographic area are effective for 1 year. In evaluating reclassification applications, the MGCRB considers 1 year of hospital wage data.

Provision:

- Under this provision, MGCRB wage index decisions are effective for 3 years. However, the Secretary is required to establish procedures for a hospital to elect to terminate this decision if it so chooses before the end of the 3-year period.

- The MGCRB is required to use the most recently published hospital wage survey data and the 2 immediately preceding surveys in making reclassification decisions for purposes of the wage index.

- The provision requires the Secretary to establish a process under which a representing statewide entity may apply to have all the geographic areas in a State treated as a single area for hospital wage index purposes. (The process is to be the same as that used for the physician fee schedule). If the Secretary applies a Statewide wage index, hospitals within the State would be prohibited from applying to the MGCRB for reclassification.

- The provision requires the Secretary to provide for the collection of data every 3 years on occupational mix in order to construct an occupational mix adjustment in the hospital wage index.

Effective Date:

- The provision making MGCRB decisions effective for 3 years is effective beginning in FY 2001.

- The provision establishing that MGCRB decisions are to be based on 3 years of wage

data is effective for decisions on applications for FY 2003 and thereafter.

- The Statewide wage index process is to be established by October 1, 2001 for reclassifications beginning in FY 2003.

- The Secretary is required to complete the collection of occupational mix data by September 30, 2003, for applications beginning October 1, 2004.

Refinement of Prospective Payment System for Inpatient Services of Rehabilitation Hospitals (Section 305)

Prior Law:

- The BBA required the Secretary to implement a PPS for inpatient rehabilitation facilities by October 1, 2000. For fiscal years 2001 and 2002, aggregate payments can be no more than 98 percent of what they would have been absent a PPS. Total payments to each facility are comprised of a blend of a facility-specific rate and the Federal rate for the first 2 cost-reporting periods after implementation. The BBRA further required implementation of a per-discharge PPS based on functional-related groups.

Provision:

- The provision requires aggregate payments to be equal to what they would have been absent a PPS for fiscal year 2002.

- The provision also allows facilities to elect to bypass the transition and to be paid at the full Federal rate.

Effective Date:

- Effective as if included in the BBA.

Increase in Payment for Inpatient Services of Psychiatric Hospitals (Section 306)

Prior Law:

- Under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), inpatient psychiatric facilities exempt from the inpatient hospital PPS are reimbursed on the basis of costs, but in almost all circumstances, there is an upper limit on cost reimbursement, referred to as the TEFRA ceiling. The ceiling is calculated on the basis of the lower of: (1) a facility-specific target amount based on the facility's individual cost history in a base year; or (2) the 75th percentile of all target amounts for similar facility types. Thus, psychiatric facilities are paid on the basis of cost, but only up to a ceiling calculated using the lower of a facility-specific target amount or the national 75th percentile cap.

- Psychiatric facilities are eligible to receive bonus payments when their operating costs are lower than their ceilings. The amount of the bonus payment is the lesser of 15 percent of the difference between costs and the ceiling or 2 percent of the ceiling.

Provision:

- The bonus provisions are changed for one year, but not how the TEFRA ceiling is calculated (including the use of a national 75th percentile cap). Specifically, the provision increases the allowable incentive payment from the lesser of (1) 15 percent of the difference between costs and the TEFRA ceiling; or (2) 3 percent of the ceiling.

Effective Date:

- Effective for cost reporting periods beginning on or after October 1, 2000 and before October 1, 2001.

Payment for Inpatient Services of Long-Term Care Hospitals (Section 307)

Prior Law:

- Like psychiatric facilities excluded from inpatient hospital PPS, long-term care hospitals excluded from PPS are reimbursed on a reasonable cost basis, but are subject to a ceiling calculated using the lower of a facility-specific target amount or a 75th percentile national cap. Excluded long-term care hospitals also may receive bonus payments.

- The BBRA requires the Secretary to develop and implement, by October 1, 2002, a per discharge PPS for long-term care hospitals to replace cost reimbursement.

Provision:

- The provision affects the 75th percentile cap and the facility-specific target amount, but not the bonus payments. Specifically, it increases both the national cap and the facility-specific target amounts for excluded long-term care hospitals -- the cap is increased by 2 percent, and the target amount by 25 percent until HCFA implements PPS for long-term care hospitals. Excluded long-term care hospitals are still paid at the lower of the cap or the target, but both the cap and the target are increased.

- The provision also requires the Secretary to examine the feasibility and impact of basing a PPS for long-term hospitals on a modified diagnosis-related group system -- the system currently used to prospectively reimburse hospital inpatient departments.

- The provision further requires the Secretary to examine and provide for appropriate adjustments to the long-term hospital payment system, including adjustments to: DRG weights, area wage adjustments, geographic reclassification, outlier, updates, and a disproportionate share adjustment.

- Should the Secretary fail to develop and implement a PPS by the date required by the BBRA, the Secretary is required to implement a PPS using existing DRGs.

Effective Date:

- The provision changing the cost-based reimbursement is effective for 1 cost year only -- for cost reporting periods beginning on or after October 1, 2000.

Subtitle B -- Adjustments to PPS Payments for Skilled Nursing Facilities

Elimination of Reduction in Market Basket for SNF PPS in 2001 (Section 311)

Prior Law:

- The BBA established a prospective payment system for SNFs and required the Secretary to update the payment rates under SNF PPS by the market basket minus 1 percentage point for FYs 2001 and 2002. SNFs receive a full market basket update for FY 2003.

Provision:

- This provision provides a full market basket increase to the SNF PPS rates for FY 2001 and the market basket minus 0.5 percentage point for FYs 2002 and 2003.

- The Secretary is required to study different systems for categorizing patients in SNFs in a manner that accounts for the relative resource utilization of different patient types.

- The GAO is required to report on the adequacy of Medicare payments to SNFs and the extent to which Medicare contributes to the financial viability of SNFs. The report is due by July 1, 2002.

Effective Date:

- The SNF update is effective April 1, 2001. For fiscal year 2001, SNFs receive the market basket minus 1 percent for October 1, 2000 through March 31, 2000 (the rate in effect under the BBA). For the period April 1, 2001 through September 30, 2001, SNFs receive the market basket plus 1 percent. Over the year, the effect is as if the SNF received the full market basket for fiscal year 2001.

- The Secretary's report to Congress is due by January 1, 2005.

Increase in Nursing Component of PPS Federal Rate (Section 312)

Prior Law:

- The BBA required the development and implementation of a per diem prospective payment system for SNFs. Under the PPS, SNF payment rates encompass all costs of furnishing covered skilled nursing services (routine, including nursing; ancillary; and capital-related costs). The transition to the PPS began for cost reporting periods starting on or after July 1, 1998.

Provision:

- The provision temporarily increases by 16.66 percent, the nursing component of the Federal payment rate.

- The GAO is required to audit nurse staffing ratios in a sample of nursing facilities and report to Congress by August 1, 2002. The report is to include an assessment of the impact of the increased payments on increased nursing staff ratios and make recommendations on whether the increase in the nursing component should continue.

Effective Date:

- Effective for services furnished on or after April 1, 2001 and before October 1, 2002.

Application of SNF Consolidated Billing Requirement Limited to Part A Covered Stays (Section 313)

Prior Law:

- The BBA requires SNFs to have the sole billing responsibility for all services (except for a short list of excluded services) that it provides to its residents. In conjunction with the SNF PPS, the Secretary implemented consolidated billing for services provided to residents in Part A-covered stays on July 1, 1998. Implementation of consolidated billing for services provided to residents not in Part A-covered stays has been delayed.

Provision:

- This provision limits the consolidated billing requirement to Part A-covered stays and to therapy services furnished during Part A-and Part B-covered stays.

- The Office of the Inspector General is required to monitor payments made under Part B to residents of SNFs during the time that the residents are not being provided care under Part A, to ensure that there is no duplicate billing for services or excessive services provided.

Effective Date:

- Effective for services furnished on or after January 1, 2001.

Adjustment of Rehabilitation RUGs to Correct Anomaly in Payment Rates (Section 314)

Prior Law:

- The BBA required development and implementation of a per diem prospective payment system (PPS) for skilled nursing facilities. Under the PPS, payments are made on the basis of patient group payment categories, known as resource utilization groups (RUGs). The BBRA established a temporary 20 percent increase for 15 RUGs relating to high cost patients (extensive services, special care, clinically complex, and 3 rehabilitation groups). The 20 percent increase terminates when the Secretary implements a refined case mix classification system for SNF PPS.

Provision:

- The BIPA modified the BBRA to place a 6.7 percent add-on to all of the RUGS rehabilitation categories rather than the BBRA's 20 percent add-on for only 3 specific RUGS rehabilitation categories. The lower percentage add-on provided in the BIPA allows for budget neutrality between the 2 add-on approaches.

Effective Date:

- Effective for services furnished on or after April 1, 2001; it remains in effect until the Secretary implements case mix refinements.

Establishment of a Process of Geographic Reclassification for SNFs (Section 315)

Prior Law:

- Current law does not provide for geographic reclassification for SNFs.

Provision:

- This provision permits the Secretary to establish a procedure for geographic reclassification for SNFs under PPS. It requires the Secretary to collect the data necessary to establish a wage index for SNFs prior to establishing such a process.

Effective Date:

- Upon enactment.

Subtitle C -- Hospice Care

Five Percent Increase in Payment Base (Section 321)

Prior Law:

- The BBRA increased payments to hospices for FY 2001 by 0.5 percent (resulting in an effective update of the market basket - 0.5) and for FY 2002 by 0.75 percent (resulting in an effective update of MB-0.25). The additional payments are not to be included in the base for future updates.

Provision:

- This provision increases hospice base payment rates by 5.0 percentage points in FY 2001. The BBRA increases remain in effect.

- The Secretary is required to use 1.0043 as the Wichita, Kansas hospice wage index for FY 2000.

Effective Date:

- Effective for care furnished on or after April 1, 2001.

Clarification of Physician Certification (Section 322)

Prior Law:

- For a beneficiary to be eligible for the hospice benefit, the individual's attending physician and the hospice medical director must certify that the patient is terminally ill.

Provision:

- This provision clarifies that certification of an individual's terminal illness must be based

on the physician's or the medical director's clinical judgment regarding the normal course of the individual's illness.

- This provision also requires the Secretary to study and report on the appropriateness of the certification process regarding terminal illness and any recommendations for legislation.

Effective Date:

- Effective for certifications made on or after enactment. The report is due not later than 2 years after enactment.

MedPAC Report on Access to, and Use of, Hospice Benefit (Section 323)

Prior Law:

- No provision.

Provision:

- The provision requires MedPAC to examine the factors affecting the use of hospice benefits, including delays in the time, relative to death, of entry into the hospice program.

Effective Date:

- The report is due 18 months after enactment.

Subtitle D -- Other Provisions

Relief from Medicare Part A Late Enrollment Penalty for Group Buy-In for State and Local Retirees (Section 331)

Prior Law:

- Retirees not otherwise entitled to Medicare Part A may enroll during a regulatorily-prescribed enrollment period and process. Delayed enrollment results in these enrollees being charged higher premiums.

Provision:

- The provision exempts certain State and local retirees from statutory penalties for delayed enrollment in Part A. The amount of the delayed enrollment penalty which would otherwise be assessed would be reduced by an amount equal to the total amount of Medicare payroll taxes paid by the employee and the employer on behalf of the employee.

Effective Date:

- Applies to premiums for months beginning with January 1, 2002.

TITLE IV -- PROVISIONS RELATING TO PART B

Subtitle A -- Hospital Outpatient Services

Revision of Hospital Outpatient PPS Payment Update (Section 401)

Prior Law:

- The BBA established a prospective payment system (PPS) for hospital outpatient departments (OPD). Generally, the OPD PPS increase factor is the hospital market basket update. The BBA set the increase factor for 2000, 2001, and 2002 at the hospital inpatient market basket percentage increase minus 1 percent.

Provision:

- The provision provides a full market basket update for services furnished during calendar year 2001. Under a "special rule," this increase will be implemented by paying for services furnished between January 1, 2001 and March 31, 2001 under the current fee schedule, updated by the market basket percentage increase minus 1. For services furnished between April 1, 2001 and December 31, 2001, payment will be the 2000 fee schedule updated by the full market basket plus an additional .32 percent. The combination of these increases provides an increase in payment equivalent to a full market basket update for all of 2001. (See also Section 547.)

- If the Secretary determines that adjustments to the PPS have or are likely to result in a change in aggregate PPS payments due to changes in coding or classification of covered OPD services that do not reflect real changes in the service mix, the Secretary may adjust the conversion factor to eliminate the effect of those coding or classification changes.

Effective Date:

- The full market basket update is effective upon enactment.

- The provision allowing the Secretary to adjust for certain coding changes is effective as if included in the BBA.

Clarifying Process and Standards for Determining Eligibility of Devices for Pass-Through Payments Under Hospital Outpatient PPS (Section 402)

Prior Law:

- BBRA established temporary additional pass-through payments for certain innovative drugs, devices, and biologicals under the hospital outpatient PPS. It names several types of current drugs and devices that qualify for pass-through payments and sets forth two criteria under which new drugs, devices, or biologicals could qualify for these payments.

- The criteria are:

  -- A new item must not have been paid for in an outpatient setting as of December 31, 1996; and

  -- Its costs must be "not insignificant" in relation to the ambulatory payment

classification (APC) payment amount. ("Not insignificant" costs were defined in an April 7, 2000 interim final rule and revised in an August 3, 2000 interim final rule.)

- Eligible items receive pass-through payments for between 2 and 3 years. Pass-through payments for eligible devices are the difference between the hospital's charges for the eligible device and the amount included in the APC payment that is associated with the device. Pass-through payments for eligible drugs and biologicals are the difference between 95 percent of the eligible drug's or biological's average wholesale price and the amount included in the APC payment for that item.

- Under the BBRA, HCFA has been determining eligibility for pass-through payments by evaluating individual brands of devices.

Provision:

- In determining the eligibility of new devices, the Secretary is required to use a category method rather than evaluating individual brands of devices. If a device falls into a described category and meets certain requirements relating to FDA approval, it will be eligible for a pass-through payment regardless of whether it was available prior to 1997. The provision does not change the evaluation process for drugs or biologicals.

- The category system must be established by April 1, 2001. Each medical device that meets the requirements for pass-through payment as of January 1, 2001 must be included in no more than 1 category. This determination of whether a medical device meets the pass-through requirements as of January 1, 2001 must be made on the basis of the program memoranda issued prior to January 1, 2001. The initial categories may be established through program memoranda after consultation with affected parties.

- By July 1, 2001, the Secretary must establish through rule-making, a list of criteria for creating additional categories. The criteria will include a test of whether the average cost of devices to be included in the category which are in use at the time the category is established meets the "not insignificant" cost requirements. Additional categories will be created for devices that are not described by existing categories and which meet the pre-BIPA statutory requirements for new devices.

- Beginning 30 days after the date of enactment of BIPA, the Secretary must begin making pass-through payments for items which are not currently eligible, but which the Secretary determines are likely to be described by an initial category.

- The period for which a category is in effect is 2 to 3 years; the time is counted from the date payment is first made for any device described by the category. For the initial categories, this clock starts running on the date the first pass-through payments were made for any device described by the category, including payments made prior to April 1, 2001.

- Once the category system is established, the pre-BIPA eligibility requirements for pass-through payments are treated as met (including the date requirement) if a device is

described by an initial category or is described by an additional category, and has an approved application under section 515 of the Federal Food, Drug, and Cosmetic Act, has been cleared for market under section 510(k) of that Act, or is exempt from the 510(k) requirements. The Secretary may not require prior approval or application for individual devices to receive payment under the category system.

Effective Date:

- Upon enactment.

Application of OPD PPS Transitional Corridor Payments to Certain Hospitals That Did Not Submit a 1996 Cost Report (Section 403)

Prior Law:

- Under BBRA, hospitals and certain other providers receive additional transitional payments for services paid under the outpatient department (OPD) PPS. These payments are phased out by 2004. Payments are calculated using a hospital's actual reimbursement for OPD services furnished during the cost reporting period ending in 1996. Hospitals without a 1996 cost report, such as those that are new to the program, cannot receive transitional corridor payments.

Provision:

- The provision allows transitional payments for all providers by authorizing the use of the oldest available cost report from the cost-reporting period ending after 1996 and before 2001 for providers without a 1996 cost report.

Effective Date:

- Effective as if included in the BBRA.

Application of Rules for Determining Provider-based Status for Certain Entities (Section 404)

Prior Law:

- Current law does not address provider-based determinations. The Secretary has developed regulations to be used to make provider-based determinations and would implement them for cost reporting periods beginning on or after January 10, 2001.

Provision:

- The provision would allow any facilities treated as provider-based as of October 1, 2000 to continue to be treated as provider-based until October 1, 2002. Also, for facilities not previously treated as provider-based, but who apply for provider-based status after October 1, 2000, HCFA is required to pay such applicants as provider-based until a determination of provider-based status is made.

- Facilities can meet the geographic location requirements for provider-based status if they

meet the qualifications detailed in the regulations or if they are located no more than 35 miles from the main campus of the hospital. A facility is treated as meeting the geographic location requirements for provider-based status if it is owned and operated by a hospital that: (1) is owned or operated by a State or local government or is a nonprofit corporation that is formally granted governmental powers by State or local government, or is a private hospital with a contract with State or local government to operate off-campus clinics serving a low-income population; and (2) has a disproportionate share adjustment percentage greater than 11.75 percent.

Effective Date:

- Upon enactment.

Treatment of Children's Hospitals Under Prospective Payment System (Section 405)

Prior Law:

- Small rural hospitals (those with no more than 100 beds) and designated cancer hospitals are held harmless under outpatient PPS. Their payments under outpatient PPS cannot fall below what they would have received under the previous payment system, as calculated using their 1996 payment to cost ratio. This protection lasts until January 1, 2004 for small rural hospitals and is permanent for cancer hospitals.

- The Secretary is authorized to create a separate conversion factor for cancer hospitals that takes into account the unique costs of cancer hospitals due to their patient population and the intensity of the services provided. The conversion factor is used to determine the Medicare payment amounts for each ambulatory payment classification (APC) group.

Provision:

- The provision gives children's hospitals the same permanent hold-harmless protection as cancer hospitals under outpatient PPS. The Secretary may also create a separate conversion factor for children's hospitals.

Effective Date:

- As if included in the BBRA.

Inclusion of Temperature Monitored Cryoablation in Transitional Pass-through for Certain Medical Devices, Drugs, and Biologicals Under OPD PPS (Section 406)

Prior Law:

- BBRA established additional pass-through payments for innovative drugs, devices, and biologicals. It names several types of current drugs and devices that qualify for pass-through payments and sets forth 2 criteria under which new drugs, devices, or biologicals can qualify for pass-through payments.

- The following types of current items are eligible for pass-through payments: orphan drugs, cancer therapy drugs and biologicals, radiopharmaceutical drugs and biologicals,

and devices of brachytherapy.

Provision:

- The provision includes current devices of temperature-monitored cryoablation as qualifying for pass-through payments.

Effective Date:

- Effective for devices furnished on or after April 1, 2001.

Subtitle B -- Provisions Relating to Physicians' Services

GAO Studies Relating to Physicians' Services (Section 411)

Prior Law:

- No provision.

Provision:

- The provision requires GAO to conduct 2 studies and submit reports to Congress by July 1, 2001.

- The purpose of the first study is to examine the appropriateness of furnishing in physicians' offices, specialist physicians' services (such as gastrointestinal endoscopic physicians' services) which are ordinarily furnished in hospital OPDs. GAO is required to: review available scientific and clinical evidence about the safety of performing procedures in physicians' offices and OPDs; assess whether resource-based practice expense relative values established by the Secretary for specialist services furnished in physicians' offices and OPDs create an incentive to furnish services in physicians' offices instead of OPDs; and assess the implications for access to care for beneficiaries if Medicare were not to cover specialist services furnished in physicians' offices.

- The second study is on the refinements to the practice expense relative value units during the transition to a resource-based practice expense system for Medicare physician payments. The study is to examine how the Secretary has accepted and used practice expense data submitted pursuant to the BBRA provision which allows use of data submitted by outside entities and organizations.

Effective Date:

- Upon enactment; GAO reports are due July 1, 2001.

Physician Group Practice Demonstration (Section 412)

Prior Law:

- The Secretary has general authority to test new payment systems or services that would improve the efficiency of the Medicare program.

Provision:

- The provision establishes a demonstration to test financial incentives to encourage care coordination and administrative efficiency and to reward physician efforts to improve health outcomes. The focus is on services provided in a group-practice setting, although the Secretary has discretion to determine that a "health care group" may include a hospital or other provider, in addition to physicians.

- The Secretary must determine the criteria for identifying beneficiaries within the scope of the demonstration and ensure that those beneficiaries are notified of the incentives and any applicable waivers of coverage or payment rules. Eligible beneficiaries must be enrolled under Part B and entitled to Part A benefits, and may not be enrolled in a Medicare+Choice plan. Beneficiary participation in the demonstration is voluntary.

- Payments are made on a fee-for-service basis to a single entity. Payment under the demonstration is payment in full for the item or service, except for the collection of the applicable deductible or coinsurance amount.

- Incentives are based on performance standards established by the Secretary, who must determine a target base expenditure amount for the participating health care group and adjust it for the demonstration patients, based on risk and expected growth rates. A portion of any savings relative to the performance target will be paid to the group.

- Additional bonuses may be awarded for process and outcome improvements that meet criteria determined by the Secretary.

- Aggregate expenditures under the demonstration, including bonus payments, must be budget neutral.

- The demonstration may be administered through program administration contracts and the Secretary may award bonus payments to program administrators. Medicare contractors may be program administrators.

- The following determinations by the Secretary are not subject to judicial review:

    -- to limit the demonstration to a geographic area, to a number of beneficiaries or entities furnishing items or services, to an element of the program that the Secretary determines suitable, or any combination of these limitations;

    -- the establishment of program participation standards or denial, termination, or refusal to renew an agreement to provide items or services under the demonstration,

    -- the establishment of performance standards for program administration contracts or the refusal to renew or the noncompetitive award or renewal of a program administration contract,

    -- the establishment of payment rates, or

    -- the determination of the existence or amount of cost savings and whether,

to whom, and in what amount, bonuses will be paid.

- The Secretary must report to Congress 2 years after enactment and biennially for the following 6 years, on the impact of the demonstration on the expenditures, access, and quality of the Medicare program.

- GAO must report to Congress within 2 years after the demonstration is implemented on the demonstration, including any recommendations for changes.

Effective Date:

- Upon enactment.

Study on Enrollment Procedures for Groups that Retain Independent Contractor Physicians (Section 413)

Prior Law:

- No provision.

Provision:

- The GAO is required to study the enrollment process for groups that retain independent contractor physicians. The study is to focus on program integrity issues as well as the costs of the enrollment process to both Medicare and the groups that contract with physicians.

Effective Date:

- The report is due to Congress within 1 year of enactment.

Subtitle C -- Other Services

1-Year Extension of Moratorium on Therapy Caps; Report on Standards for Supervision of Physical Therapy Assistants (Section 421)

Prior Law:

- The BBA increased monetary limits on physical and occupational therapy services and expanded the services covered under those limits to include all outpatient therapy services not provided by a hospital outpatient department. (Previously, the limits had applied only to therapists in independent practice.) In 1999, 2000, and 2001, physical and occupational therapy services were limited to $1,500 each per beneficiary (previously they had been limited to $900).

- The BBRA placed a moratorium on these limits in 2000 and 2001 and required focused medical review of physical and occupational therapy claims, with an emphasis on such claims for residents of skilled nursing facilities.

- The BBA required a report to Congress by January 1, 2001 on recommendations for a revised coverage policy for outpatient physical and occupational therapy based on the

diagnosis and prior use of services to replace the uniform dollar limits. This requirement was amended under the BBRA to include recommendations on a mechanism for appropriate utilization of therapy services and the establishment of an alternative payment policy based on diagnostic category, functional status, and prior use of services. The BBRA also requires the Secretary to study utilization patterns for therapy services provided in 1998 and 1999 and after January 1, 2000 and to report to Congress on this study by June 30, 2001.

Provision:

- The provision extends the moratorium on the per beneficiary limits through 2002. The focused medical reviews are continued through the additional year of the moratorium.

- The Secretary is required to study the implications of eliminating the requirement that physical therapists be in the room when services are provided by therapy assistants and billed by such a therapist. A report on this study is due June 21, 2002.

Effective Date:

- Upon enactment.

Update in the Renal Dialysis Composite Rate (Section 422)

Prior Law:

- The BBRA provided a 1.2 percent increase in the renal dialysis composite rate for 2000 and 2001.

- Under current regulations, an increase in the composite rate triggers an opportunity for facilities to request an exception to the composite rate in order to receive higher payments.

Provision:

- This provision increases the 2001 update to 2.4 percent. Under a "special rule," this increase will be implemented by paying for services furnished between January 1, 2001 and March 31, 2001, using the 2000 composite rate updated by 1.2 percent. For services provided during the rest of 2001, payment will be made using the 2000 composite rate, updated by 2.4 percent, plus an additional transitional percentage allowance equal to 0.39 percent. The combination of these increases provides an increase in payment equivalent to a 2.4 percent update for all of 2001 (also see section 547).

- Facilities that did not request an exception during 2000 may submit an application for an exception prior to July 1, 2001. Except for these potential exceptions, no new exception will be granted. All existing exceptions and new exceptions resulting from an application received prior to July 1, 2001, will remain in place as long as the rate is greater than the composite rate.

- The Secretary is responsible for conducting and reporting on 2 studies by July 1, 2002. One study will collect data and develop an ESRD market basket and develop

recommendations regarding the appropriateness of an annual update to the composite rate. The other study will determine the appropriateness of creating a more comprehensive composite rate which would include routinely furnished drugs and diagnostic procedures.

- The GAO is responsible reporting by January 1, 2003 on: the adequacy of access to dialysis services; the appropriateness of payment levels relative to audited costs; and improvements in access that could result from increased use of long nightly, and short daily hemodialysis modalities.

Effective Date:

- Services provided on or after January 1, 2001.

Payment for Ambulance Services (Section 423)

Prior Law:

- The BBA mandated the creation of a fee schedule for ambulance services and provided a reduced payment update of CPI-U minus 1 percent for 2001 and 2002.

Provision:

- The provision eliminates the payment reduction mandated by the BBA for 2001 (leaving it in place for 2002). A “special rule for payment for 2001" specifies that, for services furnished from January through June 2001, the payment update will still be calculated under prior law (CPI-U minus 1 percent), but for services furnished from July through December, 2001, payment will increase by 4.7 percent. The combination of these increases provides an increase in payment equivalent to a full CPI update for all of 2001. (Also see Section 547).

- The provision also provides full payment of national mileage rates under the ambulance fee schedule for suppliers in States where ambulance payment made by carriers to all suppliers in the State did not, prior to implementation of the fee schedule, include a separate amount for mileage within the county where the beneficiary is picked up.

Effective Date:

- The provision regarding certain mileage payments begins on the date the fee schedule is first implemented.

Ambulatory Surgical Centers (Section 424)

Prior Law:

- Medicare pays for ambulatory surgical centers' (ASC) services using prospective rates based on a survey of ASC costs. Current rates are based on 1986 survey data; in 1998, HCFA published a proposed rule to update ASC rates with 1994 data. A final rule has not been published.

- The BBRA required that, if the payment system is updated before data is incorporated from a 1999 or later cost survey, the implementation of such an update must be phased in over 3 years.

Provision:

- The provision prohibits implementation of a revised payment system before January 1, 2002 and extends the phase-in of an update using pre-1999 data to 4 years.
- The payment system must be updated with data from a 1999 or later cost survey by January 1, 2003.

Effective Date:

- Upon enactment.

Full Update for Durable Medical Equipment (Section 425)

Prior Law:

- The BBA provided an update freeze for DME through 2002. The BBRA provided a temporary payment increase for all DME of 0.3 percent in 2001 and 0.6 percent in 2002.

Provision:

- The provision provides a full CPI update in 2001 for durable medical equipment (except oxygen and oxygen equipment). Under a "special rule," for the period January 1, 2001 through June 30, 2000, the fee schedule will still be based on prior law. For the period July 1, 2001 through December 31, 2001, the fee schedule would be increased 3.7 percent over 2000, plus a transitional increase of 3.28 percent. The combination of these increases provides an increase in payment equivalent to a full CPI update for all of 2001. (Also see Section 547).

Effective Date:

- For items furnished on or after January 1, 2001.

Full Update for Orthotics and Prosthetics (Section 426)

Prior Law:

- The BBA limited the update for orthotics and prosthetics for 1998 through 2002 to 1 percent.

Provision:

- The provision provides for a full CPI update for orthotics and prosthetics in 2001. Under a "special rule," for the period January 1, 2001 through June 30, 2000, the fee schedule will still be based on prior law. For the period July 1, 2001 through December 31, 2001, the fee schedule would be increased 3.7 percent over 2000, plus a transitional increase of 2.6 percent. The combination of these increases provides an increase in payment

equivalent to a full CPI update for all of 2001. (Also see Section 547)

Effective Date:

- For items furnished on or after January 1, 2001.

Establishment of Special Payment Provisions and Requirements for Prosthetics and Certain Custom Fabricated Orthotic Items (Section 427)

Prior Law:

- No provision. However, current supplier standards in the regulations require suppliers to meet "business" standards, such as having liability insurance of at least $300,000, having posted signs showing business hours, and having a listed telephone number.

Provision:

- Under this provision, Medicare will cover prosthetics and certain custom-fabricated orthotics only if furnished by a "qualified practitioner" and fabricated by a "qualified practitioner" or "qualified supplier." The Secretary, in consultation with experts, is required to establish and periodically update a list of custom-fabricated orthotics subject to this provision.

- A "qualified practitioner" is defined as:

  -- a physician, a qualified physical or occupational therapist, and a State-licensed orthotist or prosthetist; or

  -- in States that do not issue such licenses, a trained individual who is either: (1) certified by either the American Board of Certification in Orthotics and Prosthetics, Inc. or the Board for Orthotist/Prosthetist Certification, or (2) who is credentialed by a program approved by the Secretary.

- A "qualified supplier" is an entity accredited by: the American Board for Certification in Orthotics and Prosthetics, Inc.; the Board for Orthotist/Prosthetist Certification; or a program that the Secretary determines has equivalent standards.

- The Secretary is required to issue regulations within 1 year, using a negotiated rulemaking process.

- Within 6 months of enactment, the Comptroller General is to report to Congress on HCFA Ruling 96-1. The report is to address: the Secretary's compliance with the Administrative Procedures Act; the impact of the ruling on certain beneficiaries; the potential for fraud and abuse in the provision of orthotics used as a component of DME if supplied only by "qualified practitioners;" and the effect on Medicare and Medicaid payments if that ruling were overturned.

Effective Date:

- Effective not later than 1 year after enactment, with the publication of revised

regulations.

Replacement of Prosthetic Devices and Parts (Section 428)

Prior Law:

- Items can be replaced if they are lost, stolen, or irreparably damaged (cost to repair the device exceeds the cost to replace the device). An item can also be replaced if the reasonable useful lifetime for the item has expired. The reasonable useful lifetime is established by HCFA through program instructions. In the absence of program instructions, carriers may determine the reasonable useful lifetime of an item, but in no case can it be less than 5 years.

Provision:

- The provision authorizes replacement of artificial limbs, or parts for such devices before the end of the normal 5-year period if ordered by a physician due to the following conditions (as determined by the physician): a change in physiological condition of the patient; irreparable change in the condition of the device or part; or the cost of repair of the device or part being more than 60 percent the cost of replacement.

- In the case of devices or parts that are less than 3 years old, the Secretary could require confirmation of the need for replacement.

Effective Date:

- Applies to items replaced on or after April 1, 2001.

Revised Part B Payment for Drugs and Biologicals and Related Services (Section 429)

Prior Law:

- The BBA required that currently covered Medicare drugs and biologicals that are not paid on a cost or prospective rate basis be paid at 95 percent of the average wholesale price.

Provision:

- The provision requires GAO to conduct a study on several aspects of the payment methodology for currently covered Medicare drugs and report to Congress by 9 months after enactment. GAO is required to: identify the average prices at which drugs are acquired by physicians and other suppliers; quantify the difference between average acquisition prices and Medicare payment levels; and determine the extent, if any, to which Medicare payment is adequate to compensate physicians, providers, and suppliers for the costs incurred in the administration, handling, or storage of drugs. GAO is required to provide specific recommendations for revised payment methodologies for drugs, biologicals and related services which may include proposals to adjust, if appropriate, practice expense relative values or make new payments for the costs incurred in administration, handling, or storage of drugs. GAO is also required to consider the method and amount of reimbursement made by large group plans for similar drugs, the

potential, as a result of any revised payment methodology, for patients to receive hospital services in lieu of services in physicians' offices and the effect of any revised payment methodology on the delivery of drugs in OPDs.

- The provision requires the Secretary, based on the GAO recommendations, to revise the Medicare payment methodology for drugs. The provision authorizes the Secretary to increase practice expense relative values or make new payments for the costs incurred in administration, handling, or storage of drugs as determined appropriate by the Secretary. The provision requires that any changes in payment be done in a manner that does not increase aggregate projected Medicare drug payments.

- The provision places a moratorium on decreases in payment rates for drugs and biologicals furnished on or after January 1, 2001, from rates in effect on that date until after the Secretary has reviewed the GAO report.

Effective Date:

- The moratorium is effective upon enactment; the GAO report is due 9 months after enactment.

Contrast Enhanced Diagnostic Procedures Under Hospital Prospective Payment System (Section 430)

Prior Law:

- No provision. Under existing outpatient PPS regulations, however, procedures using contrast media and related procedures which do not use contrast media are included in the same ambulatory payment classification (APC) and therefore receive the same payment amount.

- Contrast media are considered supplies and therefore are not eligible for pass-through payments.

Provision:

- The provision requires the Secretary to create additional groups of covered OPD services for procedures using contrast agents.

- The provision changes the way Medicare pays for contrast agents by classifying them as drugs. Contrast agents will now be paid "incident to" a physician service and receive 95 percent of the average wholesale price (AWP).

- As drugs, contrast agents are now eligible for outpatient PPS pass-through payments if they meet the criteria for eligibility as new drugs. Those criteria are:

  -- a new item must not have been paid for in an outpatient setting prior to December 31, 1996; and

  -- its costs must be "not insignificant" in relation to the ambulatory payment classification (APC) payment amount. ("Not insignificant" costs were defined in

an April 7, 2000 interim final rule and revised in an August 3, 2000 interim final rule.)

Effective Date:

- July 1, 2001.

Qualifications for Community Mental Health Centers (Section 431)

Prior Law:

- In order to qualify as a provider of partial hospitalization services under Medicare, a community mental health center (CMHC) must meet the criteria established for CMHCs in the Public Health Service Act (PHSA). Those criteria include a requirement that the CMHC perform screening for admission to inpatient State psychiatric facilities. To be a Medicare provider, a CMHC must also meet applicable licensing or certification requirements for CMHCs in the State in which it is located.

Provision:

- The provision specifies that, in the case of a CMHC operating in a State that, by law, precludes the CMHC from directly providing the screening function mandated by the PHSA, the CMHC may instead provide screening services by contract with an approved entity (as determined by the Secretary).

- The provision also requires that CMHCs meet "such additional conditions as the Secretary may specify" to ensure the health and safety of beneficiaries, the effective and efficient furnishing of services, and compliance with the PHSA criteria.

Effective Date:

- The first day of the third month beginning after the date of enactment.

Payment of Physician and Nonphysician Services in Certain Indian Providers (Section 432)

Prior Law:

- Current law prohibits Medicare payments to most Federal providers. A limited exception allows payments only for the facility component of services by hospitals (including provider-based clinics) and skilled nursing facilities owned or leased by the Indian Health Service (IHS), whether operated by IHS or by an Indian Tribe or Tribal organization, as long as they meet generally applicable Medicare conditions and requirements.

Provision:

- Medicare will now pay IHS hospitals and provider-based and freestanding clinics operated by IHS or by Tribes or Tribal organizations for additional services furnished by physicians and other specified health care staff in or at the direction of the hospital or clinic, under the same situations, terms, and conditions as would apply to non-Indian hospitals and clinics. Payments will be made for services furnished under the physician

fee schedule provisions or furnished by other specified practitioners and therapists paid under a Medicare Part B fee schedule (physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives, clinical social workers, clinical psychologists, physical therapists, and occupational therapists).

Duplicate payment will *not* be made if payment is otherwise being made by Medicare for the same services (e.g., if a Tribal clinic is already billing for the services as an FQHC, or if payment for the physician's or other practitioner's services is already included in a prospective or other payment).

Effective Date:

- For services furnished on or after July 1, 2001.

GAO Study on Coverage of Surgical First Assisting Services of Certified Registered Nurse First Assistants (Section 433)

Prior Law:

- No provision.

Provision:

- The GAO is required to study the effect on both the program and its beneficiaries of covering surgical first assisting services of certified registered nurse first assistants. The GAO must consider any impact on the quality of care furnished to Medicare beneficiaries, appropriate education and training requirements for certified registered nurse first assistants who furnish first-assisting services, and appropriate rates of payment.

Effective Date:

- The report to Congress due within 1 year of enactment.

MedPAC Study and Report on Medicare Reimbursement for Services Provided by Certain Providers (Section 434)

Prior Law:

- No provision.

Provision:

- MedPAC is required to study the appropriateness of current payment rates for services provided by a certified nurse midwife, physician assistant, nurse practitioner, and clinical nurse specialist, including specifically for orthopedic physician assistants.

Effective Date:

- The report, with recommendations, is due to Congress within 18 months.

MedPAC Study and Report on Medicare Coverage of Services Provided by Certain Non-Physician Providers (Section 435)

Prior Law:

- No provision.

Provision:

- MedPAC is required to conduct a study to determine the appropriateness of Medicare coverage of the services provided by a surgical technologist, marriage counselor, pastoral care counselor, and licensed professional counselor of mental health. MedPAC must also consider the short-term and long-term benefits and costs to the program.

Effective Date:

- The report, with recommendations, is due to Congress within 18 months.

GAO Study and Report on the Costs of Emergency and Medical Transportation Services (Section 436)

Prior Law:

- No provision.

Provision:

- The provision directs the GAO to study and report to Congress on the costs of providing emergency and non-emergency medical transportation services across the range of acuity levels of conditions for which such transportation is provided. The GAO is also required to submit recommendations for any changes in methodology or payment level needed to fairly compensate transport service providers, and to ensure access to such services under Medicare.

Effective Date:

- The report, with recommendations, is due to Congress within 18 months of enactment.

GAO Studies and Reports on Medicare Payments (Section 437)

Prior Law:

- No provision.

Provision:

- The Comptroller General is required to study the post-payment audit process for physicians' services and the proper level of resources HCFA should devote to educating physicians on coding and billing, documentation requirements, and calculation of overpayments. The Comptroller General will also conduct a study of the aggregate effects of regulatory, audit, oversight, and paperwork burdens on all providers

participating in Medicare.

Effective Date:

- The report to Congress is due within 18 months and is to include recommendations in any area in which a reduction in paperwork, ease of administration, or an appropriate change in oversight and review may be accomplished. The report is to also make recommendations on additional payments or education needed to assist health care providers in understanding and complying with any legal or regulatory requirements.

MedPAC Study on Access to Outpatient Pain Management Services (Section 438)

Prior Law:

- No provision.

Provision:

- MedPAC is required to study the barriers to coverage and payment for outpatient interventional pain medicine procedures under Medicare. The study is to examine the specific barriers imposed under Medicare on the provision of pain management procedures by providers and the consistency of Medicare payment policies for pain management procedures in the different settings.

Effective Date:

- The report to Congress is due within 1 year.

TITLE V -- PROVISIONS RELATING TO PARTS A AND B

Subtitle A -- Home Health Services

1-Year Additional Delay in the Application of 15 Percent Reduction on Payment Limits for Home Health Services (Section 501)

Prior Law:

- The BBA required a 15 percent reduction in Medicare home health payments on October 1, 1999, with or without the implementation of the PPS. The Omnibus Consolidated and Emergency Supplemental Appropriations Act (OCESA) of 1999 delayed the reduction until October 1, 2000, with or without PPS. The BBRA further delayed the 15 percent payment reduction until 1 year after the implementation of the home health PPS. Six months after the implementation of the PPS, the Secretary is required to submit a report to Congress analyzing the need for the 15 percent reduction, or for any reduction in base payment amounts for home health services under the PPS.

Provision:

- This provision delays the 15 percent reduction for 1 year, and requires GAO, rather than the Secretary, to submit the report required in the BBRA. It also allows HCFA to adjust

for case mix changes that are not a result of real case mix changes.

Effective Date:

- The delay in the 15 percent reduction is effective for episodes concluding on or after October 1, 2002.

Restoration of Full Home Health Market Basket Update for Home Health Services for Fiscal Year 2001 (Section 502)

Prior Law:

- The BBA mandated that home health prospective payment amounts be adjusted by the home health market basket increase for each fiscal year starting with FY 2001. The OCESA provision, later amended by the BBRA for technical reasons, mandated that for FYs 2002 and 2003, the prospective payment amounts be adjusted by the home health market basket minus 1.1 percentage points, and adjusted by the full market basket for FYs 2004 and thereafter.

Provision:

- This provision provides home health agencies the full home health market basket update for FY 2001.

Effective Date:

- Effective for episodes and visits ending on or after April 1, 2001. For FY 2001, from October 1, 2000 through March 31, 2001, the Secretary must use the final standardized and budget neutral prospective payment amounts for 60-day episodes and standardized average per visit amounts for FY 2001, as published in the Federal Register on July 3, 2000. For episodes and visits ending on or after April 1, 2001 and before October 1, 2001, the Secretary is to use those amounts, increased by 2.2 percent. This results in the full home health market basket increase for home health agencies for FY 2001.

Temporary Two-Month Extension of Periodic Interim Payments (Section 503)

Prior Law:

- BBA, as amended by the Tax and Trade Relief Extension Act of 1998, repealed periodic interim payments to home health agencies once home health PPS began.

Provision:

- This provision extends PIP payments to home health agencies that were on PIP in September, 2000, and will pay them 4 times their last full biweekly PIP. The Secretary is permitted to make 1 single payment. The amount paid to each agency will be repaid at the tentative settlement of their last interim payment system cost report. The Secretary is prohibited from making PIP payments to agencies that: notify the Secretary that they do not wish to receive such payment; are not receiving Medicare payments pursuant to 42 CFR section 405.471 (suspension, offset or recoupment); are excluded from the Medicare

program; no longer have provider agreements; are no longer in business; or are subject to a court order providing for the withholding of Medicare payments.

Effective Date:

- Upon enactment.

Use of Telehealth in Delivery of Home Health Services (Section 504)

Prior Law:

- No provision.

Provision:

- Clarifies that home health agencies are not prevented from furnishing services via a telecommunications system if the services do not substitute for in-person home health services ordered under a plan of care and are not considered a home health visit for eligibility or payment purposes.

Effective Date:

- Upon enactment.

Study on Costs to Home Health Agencies of Purchasing Nonroutine Medical Supplies (Section 505)

Prior Law:

- Nonroutine medical supplies, such as wound care supplies and ostomy supplies, are included in the home health prospective payment system.

Provision:

- The provision requires the GAO to study the variations in prices paid by home health agencies in purchasing nonroutine medical supplies, the volume of supplies used, and the effect, if any, of variations in prices and volume in the provision of home health services.

Effective Date:

- The report is due to Congress by August 15, 2001.

Treatment of Home Health Agency Branch Offices (Section 506)

Prior Law:

- No provision. Under HCFA instructions, a branch office must be "sufficiently close [to the main office of a home health agency] to share administration, supervision, and services in a manner that renders it unnecessary for the branch independently to meet the Medicare conditions of participation as an HHA." HCFA instructions further state that, "Mileage and travel time are appropriate factors to consider, on a case-by-case basis, in

making the determination regarding the regulatory requirements of "sufficiently close."

Provision:

- This provision prevents HCFA from using solely time or distance in the determination of branch office status. The Secretary is specifically authorized to include forms of technology in determining what constitutes "supervision."

- The GAO is required to conduct a study on the provision of adequate supervision to maintain quality services in isolated rural areas. The report must include recommendations on whether exceptions are needed for sub-units and branches under Medicare to maintain access to home health services, or whether other policies should be developed.

Effective Date:

- Upon enactment. The GAO report is due January 1, 2002.

Clarification of the Homebound Definition under the Medicare Home Health Benefit (Section 507)

Prior Law:

- The statute defines homebound as having a normal inability to leave the home, and that leaving the home requires considerable and taxing effort. Moreover, absences from the home must be infrequent or of relatively short duration, or are attributable to the need to receive medical treatment. This definition is further clarified in the home health agency manual, which, for example, explains that an occasional trip to the barber, or a walk around the block would not disqualify a patient.

Provision:

- This provision would allow beneficiaries who require home health services to attend adult day-care for therapeutic, psychosocial, or medical treatment and remain eligible for the home health benefit. The provision clarifies that any absence for the purpose of attending a religious service is considered infrequent or of short duration.

- The GAO is required to evaluate the effect of permitting beneficiaries receiving home health services to attend adult day care on the cost of, and access to, home health services.

Effective Date:

- Upon enactment. The GAO report is due not later than 1 year after enactment.

Temporary Increase For Home Health Services Furnished in a Rural Area (Section 508)

Prior Law:

- No provision.

Provision:

- The Secretary is required to increase payments by 10 percent for home health services furnished in a rural area.

Effective Date:

- Effective for services furnished on or after April 1, 2001 and before April 1, 2003.

Subtitle B -- Direct Graduate Medical Education

Increase in Floor for Direct Graduate Medical Education (GME) Payments (Section 511)

Prior Law:

- The BBRA raised per resident amounts for hospitals that were below 70 percent of a geographically adjusted national average, to 70 percent of that average.

Provision:

- This provision increases the GME payment floor to 85 percent from 70 percent.

Effective Date:

- Effective for cost reporting periods beginning during fiscal year 2002.

Change in Distribution Formula for Medicare+Choice-Related Nursing and Allied Health Education Costs (Section 512)

Prior Law:

- The BBRA established additional payments for the costs associated with nursing and allied health education.

Provision:

- This provision alters the formula by which hospitals are paid for nursing and allied health education for Medicare managed care enrollees. The payment is now based on the hospital's per day cost of allied and nursing health programs and the number of days attributed to Medicare enrollees in comparison to that in all other hospitals.

Effective Date:

- Effective for portions of cost reporting periods occurring on or after January 1, 2001.

Subtitle C -- Changes in Medicare Coverage and Appeals Process

Revision to Medicare Appeals Process (Section 521)

Prior Law:

- Medicare appeals differ for Part A and Part B claims.

- In Part A appeals, the first step of appeal is an intermediary reconsideration, the second step is to an Administrative Law Judge (ALJ); the third step is to the Departmental Appeals Board (DAB), and finally, an appeal may be brought to Federal Court. Performance standards for intermediaries require most reconsiderations to be performed within 60 days. The amounts in controversy are $100 for an ALJ appeal, and $1,000 for Federal court appeals. Beneficiaries may appeal in their own name. Providers may appeal in their own name only in certain circumstances, but may represent the beneficiary in an appeal.

- In Part B appeals, there are 2 levels of appeal at the carrier level -- carrier review and then a carrier fair hearing before a hearing officer. Performance standards for carriers require most reviews to be completed within 45 days and most fair hearings to be completed within 120 days. Fair hearing decisions may be appealed to an ALJ, then to the DAB, and finally to Federal court. The amounts in controversy are $100 for a carrier fair hearing, $500 for an ALJ appeal (except for home health, which is $100), and $1,000 for Federal court. Suppliers that have accepted assignment, and beneficiaries, have their own appeal rights. Providers may appeal in their own name only in certain circumstances. Also, providers and suppliers may represent the beneficiary in an appeal.

- In both Part A and Part B appeals, appellants may aggregate claims to meet the amount in controversy. In addition, the Departmental Appeals Board is permitted to decline review of an ALJ appeal.

- In both Part A and Part B appeals, ALJs are not bound by local coverage policies, but are required to follow national coverage decisions.

- In both Part A and Part B appeals, there are no deadlines on either the DAB or the ALJ to hear appeals.

- In both Part A and Part B cases, where a provider or supplier represents the beneficiary, the provider/supplier must waive the right to receive payment for such representation. In certain cases, the provider/supplier must also waive the right to receive payment from the beneficiary for the service provided.

Provision:

- The provision creates identical processes for both Part A and Part B appeals. Initial determinations on claims must be made within 45 days. The provision allows beneficiaries to assign their appeal rights to providers -- thereby giving providers their own appeal rights in all circumstances. Beneficiaries continue to have their own appeal rights, and providers and suppliers may still represent beneficiaries. When providers and suppliers represent beneficiaries, they must waive the right to receive payment for such representation, and in certain cases, must waive the right to receive payment for the actual item or service delivered (as under prior law).

- The first step of appeal is a redetermination made by the fiscal intermediary or carrier. Parties have 120 days to request such redeterminations, and the redetermination must be made within 30 days.

- The second step of appeal is reconsideration by an independent external contractor, known as a qualified independent contractor or "QIC." Requests for reconsideration must be made within 180 days of receiving the redetermination decision (or within such additional time as the Secretary provides). The Secretary must contract with no fewer than 12 QICs, who employ panels of physicians or other appropriate health care professionals in their decision-making. Contracts are for a period of 3 years and may be renewed for 3-year periods thereafter. QICs must issue decisions within 30 days of receiving a request for review (with a possible 14-day extension at the request of the appellant). If the QIC does meet the 30-day deadline, the appellant may request a de novo appeal before an ALJ. There is no minimum amount in controversy for bringing an appeal to a QIC.

- The third step of appeal is to an ALJ. The amount in controversy is $100 or more, but claims may be aggregated to meet this threshold. ALJs have a 90-day deadline to issue their decisions from the date they received a request for review. If the ALJ misses the 90-day deadline, the appellant may request a review before the DAB. (However, the appellant may also waive their right to the 90-day deadline).

- The fourth step of appeal is to the DAB, which has a 90-day deadline to issue a decision from the date they received a request for review. If the DAB misses the deadline, the appellant may request review in Federal court. The amount in controversy for bringing a Federal court appeal is equal to or greater than $1,000.

- The law creates a 72-hour expedited review to a qualified independent contractor (QIC) in cases where an individual is about to be discharged from a provider, or where a provider plans to terminate services and a physician certifies that such termination would put the individual's health at significant risk.

- QICs and ALJs are explicitly bound by national coverage decisions, but not by local coverage policies. QICs are directed to "consider" local coverage policies, but are not bound by them.

- The Secretary is required to: (1) perform outreach activities necessary to inform individuals of their appeals benefits; (2) perform continuing education for both external review contractors and ALJs; (3) issue an annual report to Congress on the number of appeals in the previous year and any issues requiring legislation; and (4) every 5 years, conduct a survey of Medicare beneficiaries to determine their satisfaction with the appeals process.

Effective Date:

- Effective for appeals of initial determinations made on or after October 1, 2002.

Revisions to Medicare Coverage Process (Section 522)

Prior Law:

- In an April 27, 1999 Federal Register notice, HCFA announced a process for making national coverage determinations (NCDs). This process includes a time frame for

responding to formal requests for coverage and provides for a decision within approximately 90 days. A decision could include a national coverage determination, a national non-coverage decision, referral for a technology assessment, or referral to the Medicare Coverage Advisory Committee (MCAC).

- When HCFA has not issued a national coverage determination or a national non-coverage determination on an item or service, or when an NCD is silent, coverage determinations of whether an item or service is considered "reasonable and necessary" are left to the discretion of Medicare contractor. Contractors exercise this discretion by developing and issuing local medical review policies (LMRPs). Such LMRPs apply only to claims processed by the issuing contractor.

- There is no external administrative review process for national coverage determinations. NCDs are binding on Administrative Law Judges (ALJs). While an ALJ cannot strike down an LMRP, they are not binding on the ALJ; the ALJ may choose to overturn the application of the LMRP for an individual claim. Parties unhappy with an LMRP may request an NCD on the topic.

- If new evidence is available, any party may ask for a reconsideration of a NCD. Individuals dissatisfied with a LMRP can request a national coverage determination.

- If, while reviewing a NCD, a court determines that the record is incomplete or is inadequate to support the NCD, the court must remand the matter to the Secretary to supplement the record. The court can only make a determination of whether an item or service is covered once it has reviewed the supplemented record.

Provision:

- The provision modifies procedures for making NCDs in situations where a beneficiary in need of an item or service requests a NCD. It places a 90-day deadline on action by the Secretary and this deadline cannot be extended due to receipt of additional information. If a determination cannot be made within 90 days, the Secretary must identify the remaining steps required and set a new deadline for completion. If a determination is not made by this new deadline, then the Secretary is considered to have determined that neither a NCD nor a non-coverage determination is appropriate, leaving the matter to local contractor discretion.

- In general, when making any NCD, the Secretary must ensure that the public has an opportunity to comment on a NCD prior to its implementation and must identify the basis for the determination, including response to public comments and any underlying assumptions.

- The provision requires that the Secretary assure the full participation of non-voting members of advisory committees on Medicare coverage issues and provide them access to the information and data available to voting members, unless there is a trade secret exemption or a conflict of interest. Expert panels of Medicare coverage advisory committees chartered under the Social Security Act may report their recommendations directly to the Secretary without ratification of the advisory committee itself or the

executive committee of the advisory committee.

- The Secretary must report to Congress annually on the time it takes to complete and fully implement NCDs in the previous fiscal year, including the time necessary to make and implement coverage, coding, and payment determinations. This report is due by December 1 of each year, beginning in 2001, and must be posted on the Medicare website.

- Beneficiaries in need of the item or service included in an NCD or a local coverage determination (LCD) may file for a review of the coverage determination.

- Review of NCDs will be conducted by the Departmental Appeals Board (DAB), which may take evidence, consult with the appropriate scientific and clinical experts, and will look at the reasonableness of the determination. The Secretary has 30 days to implement the DAB's decision. NCDs are defined as determinations as to whether a particular item or service is covered nationally, but are not coding or payment determinations. Decisions of DAB hearings on NCDs must be posted on the Medicare website.

- Local coverage determinations are reviewed by an SSA ALJ, who may take evidence, consult with the appropriate scientific and clinical experts, and is to look at the reasonableness of the determination. Decisions by an ALJ may be appealed to the DAB. The Secretary has 30 days to implement the decision of an ALJ or the DAB. LCDs are defined as area-wide determinations by fiscal intermediaries (FIs) and carriers regarding coverage under "the reasonable and necessary" clause of the statute.

- For both NCDs and LCDs, final decisions of the DAB are subject to judicial review. The current requirement that courts remand the matter to allow the Secretary to supplement the record if it is found to be incomplete or inadequate to support the determination is eliminated.

- Beneficiaries with standing are given the opportunity for expedited judicial review if, among other things, there are no material issues of fact in dispute.

Effective Date:

- October 1, 2001.

Subtitle D -- Improving Access to New Technologies

Reimbursement Improvements for New Clinical Laboratory Tests and Durable Medical Equipment (Section 531)

Prior Law:

- Clinical diagnostic laboratory tests are paid at the lowest of the actual charge, the carrier's local fee schedule amount, or a national limitation amount established by HCFA for each test. The national limitation amount is calculated by multiplying the median of the carrier amounts by 74 percent. Durable medical equipment (DME) is paid at the lesser of the

actual charge or the State fee schedule amount. The State fee schedule amounts for DME may not be more than the median of all State fee schedule amounts or less than 85 percent of the median of all State fee schedule amounts.

- Each November, HCFA publishes instructions to the Medicare carriers that reflect how HCPCS codes established during the prior April should be paid under the laboratory fee schedule, beginning the following January 1. The HCPCS codes for DME are also revised annually, with instructions for payment of new HCPCS codes provided to the carriers in November. In addition, temporary HCPCS codes for DME can be added on a quarterly basis (April, July, and October). Payment instructions for codes added during a quarterly update are provided 3 months in advance of the quarterly update.

Provision:

- The provision sets the national limitation amount at 100 percent of the carrier median for a clinical laboratory test that the Secretary determines is a new test, and for which no national limitation amount has previously been established.

- The provision requires the Secretary to establish, within 1 year of enactment, procedures for coding and for payment determinations for new clinical diagnostic laboratory tests and for new DME paid under Part B. Public consultation is to be permitted, consistent with the procedures established for ICD-9-CM coding modifications. (For example, the ICD-9-CM Coordination and Maintenance Committee, co-chaired by HCFA and the National Center for Health Statistics, conducts 2 public meetings each year to consider provider recommendations on whether new technology should be assigned to a new or existing ICD-9-CM code. Further public comments may be submitted after the meetings for consideration in the development of a proposed rule modifying the inpatient PPS for the coming year.)

- The provision requires the Secretary to submit, within 1 year of enactment, a report to Congress identifying the specific procedures used to adjust payments for clinical diagnostic laboratory tests and DME that are based on existing payment codes (i.e., “cross walked”) in cases where, because of technology advances, there has been a significant increase or decrease in the resources used in the test or the manufacture of the equipment, and a significant improvement in the test’s or equipment's performance. The report is to include recommendations for statutory changes in order to assure appropriate payment for such improved tests and equipment.

Effective Date:

- The establishment of national limitation amounts for new clinical laboratory tests at 100 percent of the carrier median is effective January 1, 2001.

Retention of HCPCs Level III Codes (Section 532)

Prior Law:

- HCPCS consists of three levels of codes. Level I consists of Current Procedural Terminology (CPT) codes representing physicians' services and certain other services.

Level II consists of national codes covering items and services not in CPT, such as durable medical equipment and drugs. Level III consists of local codes for items and services not in Level I or II and determined to be appropriate by each Medicare carrier.

- The Health Insurance Portability and Accountability Act of 1996 requires establishment of uniform national codes. Under the HIPAA Final Rule for Standards for Electronic Transactions, HCPCS Level III codes would be eliminated.

Provision:

- The provision requires the Secretary to maintain and continue the use of local codes through December 31, 2003 and requires that the codes be made available to the public.

Effective Date:

- Upon enactment.

Recognition of New Medical Technologies Under Inpatient Hospital PPS (Section 533)

Prior Law:

- HCFA annually evaluates the most currently available data to assess whether DRG changes in the inpatient hospital prospective payment system are necessary. It usually takes 1 year from the time a procedure is assigned a code to collect the appropriate data and then another year to make an assessment as to whether a DRG change is appropriate.

Provision:

- The provision requires the Secretary to submit a report to Congress on methods of expeditiously incorporating new medical services and technologies into the clinical coding system used for payment for inpatient hospital services and a detailed description of the Secretary's preferred methods to achieve this purpose.

- The provision requires the Secretary to establish (after notice and a public comment period), a mechanism to recognize the costs of new medical services and technologies under the inpatient hospital prospective payment system.

Effective Date:

- No later than April 1, 2001, the Secretary's report is due to Congress on incorporating new medical services and technologies.

- Effective for discharges on or after October 1, 2001, the Secretary must establish a mechanism to recognize the costs of new medical services and technologies.

Subtitle E -- Other Provisions

Increase in Reimbursement for Bad Debt (Section 541)

Prior Law:

- The BBA reduces from 100 percent to 55 percent, the amount of beneficiaries' bad debt that Medicare will reimburse hospitals, beginning in FY 2000.

Provision:

- This provision increases the amount that Medicare will pay hospitals for beneficiary bad debt from 55 percent to 70 percent of the allowable costs.

Effective Date:

- Effective for cost reports beginning during FY 2001 and for subsequent years.

Treatment of Certain Physician Pathology Services under Medicare (Section 542)

Prior Law:

- In certain situations, the technical component of physician pathology services furnished to hospital patients by independent labs was billed separately, rather than being included as part of Medicare's payment to the hospital. The physician fee schedule final rule, published in November, 1999, eliminated separate payment for the technical component of physician pathology services furnished by independent labs, effective for services furnished beginning on January 1, 2001.

Provision:

- There is a grandfather provision for 2 years for situations where independent labs that separately billed Medicare for the technical component of physician pathology services furnished to hospital inpatients and outpatients prior to July 22, 1999, would be allowed to continue separate billing for 2 years (2001 and 2002).

- The provision requires GAO to conduct a study of these situations and report to Congress about whether the 2-year grandfather provision should be continued and whether such a policy should be expanded to other hospitals.

Effective Date:

- Effective for services furnished during 2001 and 2002. The GAO report is due by April 1, 2002.

Extension of Advisory Opinion Authority (Section 543)

Prior Law:

- The Health Insurance Portability and Accountability Act of 1996 (HIPAA) directed the Secretary to establish a process for issuing advisory opinions on, among other things, what constitutes prohibited remuneration under the Illegal Remuneration Act. The advisory opinion process was slated to expire 4 years after the enactment of HIPAA (by August 21, 2000).

Provision:

- This provision eliminates the expiration of the advisory opinion process, and makes the process permanent.

Effective Date:

- Upon enactment.

Change in Annual MedPac Reporting (Section 544)

Prior Law:

- MedPAC is required to submit 2 reports to Congress each year: a March 1 report making recommendations concerning Medicare, and a June 1 report that examines issues affecting Medicare and the implications for Medicare of changes in health care delivery in the United States and in the market for health care services.

Provision:

- This provision requires that the June 1 report be submitted to Congress by June 15 of each year.

- The provision adds a new requirement that for recommendations, each Commissioner must vote on the recommendations and that the results of the vote, by member, be included in the appropriate report.

Effective Date:

- Effective for reports beginning with 2001.

Development of Patient Assessment Instruments (Section 545)

Prior Law:

- Current law allows the Secretary to develop and require patient assessment instruments for use in skilled nursing facilities (SNFs), inpatient rehabilitation facilities, and home health agencies (HHAs).

Provision:

- The provision requires the Secretary to report to Congress on the development of standard instruments for the assessment of the health and functional status of patients receiving the services of acute care hospitals (both inpatient and outpatient), rehabilitation hospitals (both inpatient and outpatient), SNFs, HHAs, physical, occupational, or speech therapy, ESRD facilities, and partial hospitalization or other mental health services. The Secretary is required to consult with MedPAC, the Agency for Healthcare Research and Quality (AHRQ), and qualified organizations representing providers of services and suppliers.

Effective Date:

- The report is due by January 1, 2005

GAO Report on Impact of the Emergency Medical Treatment and Active Labor Act (EMTALA) on Hospital Emergency Departments (Section 546)

Prior Law:

- No provision.

Provision:

- The GAO is required to evaluate the effect of EMTALA on hospitals, emergency physicians, and physicians covering emergency department calls. The report is to evaluate: (1) the extent to which EMTALA requirements lead to the provision of uncompensated services; (2) the extent to which the requirements and enforcement of EMTALA have expanded beyond the original legislative intent; (3) estimates of EMTALA-related uncompensated care; (4) the extent to which different geographic areas experience different levels of uncompensated care; (5) the extent to which EMTALA would be classified as an unfunded mandate if enacted today; (6) the extent to which States have programs to fund uncompensated care; (7) possible sources of funds, including Medicare hospital bad debt accounts, available to assist hospitals with the cost of uncompensated care; and (8) the financial strain that illegal immigrants, the uninsured, and the underinsured place on hospitals and physicians providing emergency services.

Effective Date:

- The GAO report to Congress is due by May 1, 2001.

Clarification of Application of Temporary Payment Increases for 2001 (Section 547)

Prior Law:

- No provision.

Provision:

- The provision provides split-year updates and payment changes for: inpatient hospital services, indirect medical education, disproportionate share hospital payments, skilled nursing facility services, home health services, rural home health services, hospital outpatient department services, renal dialysis facility services, ambulance services, durable medical equipment and orthotics and prosthetics.

- This provision clarifies that the higher payment in the second portion of FY or CY 2001 to account for the timing of the implementation of the higher update or payment applicable to the full fiscal or calendar year applies only for FY or CY 2001 and is not built into the base to which future updates are applied.

Effective Date:

- Upon enactment.

TITLE VI -- PROVISIONS RELATING TO PART C (MEDICARE+CHOICE

PROGRAM) AND OTHER MEDICARE MANAGED CARE PROVISIONS

Subtitle A -- Medicare+Choice Payment Reforms

Increase in Minimum Payment Amount (Section 601)

Prior Law:

- Medicare+Choice capitation rates are based on the greatest of: (1) a specified minimum payment amount; (2) a blend of local and national amounts; or (3) a 2 percent increase over the prior year's rate. The minimum amount for 2001 announced on March 1, 2000 was $415.01 for the aged and $408.15 for the disabled.

Provision:

- The provision increases the minimum payment amount for 2001 to $525 within the 50 States and the District of Columbia in a county in a Metropolitan Statistical Area with a population of more than 250,000. For all other counties within the 50 States and the District of Columbia, the minimum payment amount is increased to $475. For any area outside the 50 States and the District of Columbia, the $525 and $475 minimum amounts would also be applied, except that the minimum payment amount could not exceed 120 percent of the 2000 minimum payment amount.

Effective Date:

- These rates apply beginning March of 2001. For January and February of 2001, the rates published on March 1, 2000 will apply.

Increase in Minimum Percentage Increase (Section 602)

Prior Law:

- Medicare+Choice capitation rates are based on the greatest of: (1) a specified minimum payment amount; (2) a blend of local and national amounts; or (3) a 2 percent increase over the prior year's rate.

Provision:

- This provision increases the 2 percent minimum update to 3 percent in 2001.

Effective Date:

- The rates that result from modifying the minimum percentage increase apply beginning in March of 2001. For January and February of 2001, the rates published on March 1, 2000 will apply.

Phase-In of Risk Adjustment (Section 603)

Prior Law:

- The BBA required that payments to Medicare+Choice organizations be risk adjusted no

later than January 1, 2000. In developing the risk-adjustment methodology mandated by the BBA, HCFA included a 5-year phase-in of the effects of risk adjustment. During the first 4 years, the risk adjustment methodology utilizes only data from the inpatient setting would be utilized (PIP-DCG). Beginning in 2004, risk adjustment was to be based on data from both the inpatient and from outpatient settings (e.g., comprehensive risk adjustment). The phase-in schedule under HCFA's original risk adjustment methodology was as follows: 2000, 10 percent PIP-DCG/90 percent demographic; 2001, 30 percent PIP-DCG/70 percent demographic; 2002, 55 percent PIP-DCG/ 45 percent demographic; 2003, 80 percent PIP-DCG/20 percent demographic; and 2004, 100 percent comprehensive.

- The BBRA modified the phase-in schedule by limiting the proportion of payment subject to risk adjustment to 10 percent in 2001 and not more than 20 percent of the payment in 2002. Years after 2002 were not addressed in the legislation.

Provision:

- The phase-in of risk adjustment is extended to 8 years. The limitation of 10 percent of payment subject to risk adjustment is maintained until 2004, when comprehensive risk adjustment will begin. The phase-in of the portion of payment subject to risk adjustment will then be as follows: 30 percent for 2004, 50 percent for 2005, 75 percent for 2006, and 100 percent for 2007 and subsequent years.

Effective Date:

- Upon enactment.

Transition to Revised Medicare+Choice Payment Rates (Section 604)

Prior Law:

- The BBA required that Medicare+Choice rates for a given year be announced in March of the previous year. The BBRA required that by July of that year, plans must make participation decisions and submit benefit packages -- referred to as adjusted community rate proposals (ACRP), for the following year.

Provision:

- Within 2 weeks after enactment, the Secretary must announce revised M+C capitation rates for March to December, 2001, based on requirements in sections 601 and 602 of BIPA.

- Organizations that previously had provided notice of termination or service area reductions may return to the program or their service area if they provide an ACRP within 2 weeks after the Secretary announces the revised 2001 rates.

- Existing Medicare+Choice organizations also have 2 weeks to submit revised ACRPs for M+C plans renewed for 2001. When submitting ACRPs, organizations may use additional payment amounts only to reduce premiums, reduce cost sharing, enhance

benefits, utilize benefit stabilization funds, or stabilize and enhance access to providers. Organizations choosing to use additional payment amounts to stabilize and enhance access to providers may do so only if it does not result in increased premiums, increased cost-sharing, or reduced benefits. Any regulations that limit the amounts withheld in a benefit stabilization fund are waived, with respect to ACRPs for March to December, 2001.

- Notwithstanding the issuance of revised rates, M+C organizations will continue to be paid on a fee-for-service basis for 2001 for costs associated with certain new national coverage determinations and legislative changes in benefits that are made mid-year.

Effective Date:

- Upon enactment.

Revision of Payment Rates for ESRD Patients Enrolled in Medicare+Choice Plans (Section 605)

Prior Law:

- Medicare+Choice plans with enrollees with end-stage renal disease (ESRD) are paid for these enrollees on the basis of separately calculated Statewide rates based on Medicare costs for beneficiaries with ESRD in the State.

- As part of the Social HMO (SHMO) demonstration, HCFA developed a modified payment methodology for ESRD that differentiates, among other factors, on the basis of age, renal treatment modality, and the underlying cause of the disease.

Provision:

- The provision requires the Secretary to appropriately adjust the current M+C payment rates for enrollees with ESRD to reflect the rates, including the risk adjustment methodology of the ESRD SHMO demonstration. In revising the current rates, the Secretary is to take into account such factors as renal treatment modality, age, and the underlying cause of the disease. No later than June 21, 2001, the Secretary must publish for public comment, a description of the proposed adjustments and must publish the final adjustment by not later than July 1, 2001.

Effective Date:

- Payments under the new methodology are to begin on January 1, 2002.

Permitting Premium Reductions as Additional Benefits Under Medicare+Choice Plans

(Section 606)

Prior Law:

- Under the BBA, if a Medicare+Choice (M+C) organization's cost of providing the Medicare benefit package as reflected in their adjusted community rate proposal (ACRP)

is less than the Medicare+Choice capitation rate, this "excess amount" must be used to provide additional benefits. These benefits can be non-Medicare-covered items and services or reduced beneficiary liability for Medicare items and services. The law did not authorize using excess amounts to reduce the Medicare Part B premium.

Provision:

- This provision permits Medicare+Choice organizations to offer reduced Medicare Part B premiums to their enrollees as an additional benefit funded with "excess amounts." The mechanism to fund this reduction is for the M+C organization to elect a reduction in its Medicare+Choice payment of up to 125 percent of the annual Part B premium. 80 percent of this amount will be used for premium reduction; the remaining 20 percent will be a savings to the program. As with other additional benefits, reductions in the Part B premium will have to apply uniformly to all plan enrollees.

- The Part B premium reduction will be provided directly, or as an adjustment to the applicable benefit (e.g., Social Security, Railroad Retirement.). In the case of an individual whose Part B premium is paid under the Medicaid program, the amount otherwise owed by the State for medical assistance would be adjusted.

- Information on Part B premium reductions will be included in the comparative information on Medicare+Choice options that are provided to Medicare beneficiaries.

- The appropriation to the Part B trust fund will be adjusted to reflect the impact of any plan elections on premium revenues.

  Examples:

  -- If the Part B premium is $50 and the M+C organization elects to have the full 125 percent of the Part B premium amount ($62.50) withheld from its payment for each enrollee: In this example, 80 percent of $62.50, or $50, would be applied to reducing the Part B premium. Thus, the beneficiary would not pay any portion of the Part B premium ($50 - $50 = $0).

  -- If the M+C organization elects to have 50 percent of the Part B premium amount ($25), withheld from its payment for each enrollee: In this example, 80 percent of $25, or $20, would be applied to reducing the Part B premium. Thus, the beneficiary would pay $30 of the $50 Part B premium ($50 - $20 = $30).

Effective Date:

- January 1, 2003.

Full Implementation of Risk Adjustment for Congestive Heart Failure Enrollees for 2001 (Section 607)

Prior Law:

- In developing a risk adjustment methodology mandated as required by the BBA, HCFA included a 5-year phase-in of the effects of risk adjustment as a part of this methodology.

During the first 4 years, an increasing portion of payments would be risk adjusted based only on data from the inpatient setting (PIP-DCG). Beginning in 2004, risk adjustment was to apply to 100 percent of the payment rate, and was to be based on data from both inpatient and from outpatient settings (e.g., comprehensive risk adjustment).

- The BBRA modified this schedule by limiting the proportion of payment subject to risk adjustment to 10 percent in 2001 and not more than 20 percent of the payment in 2002. Years after 2002 were not addressed in the legislation. (Note: As discussed above, Sec. 603 of BIPA would extend the transition to 8 years.)

Provision:

- This provision provides for a limited exception to the Medicare+Choice risk adjustment phase-in for 2001. While generally only 10 percent of payment will be subject to risk adjustment in 2001, payments will be fully risk adjusted in the case of enrollees who had a qualifying congestive heart failure inpatient diagnosis (for risk adjustment purposes, as determined by the Secretary) between July 1, 1999 and June 30, 2000 if the enrollee is enrolled in the only coordinated care plan offered in the service area. This additional payment amount to certain organizations will not be considered when determining budget neutrality.

Effective Date:

- Effective during the 1-year period beginning January 1, 2001.

Expansion of Application of Medicare+Choice New Entry Bonus (Section 608)

Prior Law:

- The BBRA provided a new entry bonus in areas where enrollment in a Medicare managed care plan had not been offered since 1997, or where any Medicare+Choice organizations serving the area filed notice by October 13, 1999 that they would no longer offer an M+C plan in the area as of January 1, 2000.

- Payments to Medicare+Choice organizations eligible for the bonus payments are increased by 5 percent for the first 12 months the plan is offered and by 3 percent for the second 12 months.

- The BBRA bonus only applied to Medicare+Choice plans first offered during the 2-year period beginning January 1, 2000, and only with respect to the first plan (or plans, if more than one) offered in the area on that date.

Provision:

- The provision expands the application of the new entry bonus to include areas for which notification was provided, as of October 3, 2000, that no Medicare+Choice plans would be available on January 1, 2001.

Effective Date:

- Effective as if enacted as part of BBRA.

Report on Inclusion of Certain Costs of the Department of Veterans Affairs and Military Facility Services in Calculating Medicare+Choice Payment Rates (Section 609)

Prior Law:

- The BBRA requires the Secretary to report to Congress by April 1, 2001, on the use of services furnished by the Department of Defense and the Department of Veteran Affairs to Medicare beneficiaries, including both beneficiaries in fee-for-service Medicare and beneficiaries enrolled in Medicare+Choice, and to include an analysis of how to adjust Medicare+Choice capitation rates to reflect these expenditures.

Provision:

- The Secretary is required to report to Congress by January 1, 2003, on a method to phase-in the costs of military facility services furnished by the Department of Veterans Affairs or the Department of Defense to Medicare-eligible beneficiaries in the calculation of an area's Medicare+Choice capitation rate.

- This report must include, on a county-by-county basis: the actual or estimated costs of such services to Medicare-eligible beneficiaries; the change in M+C capitation rates if such costs were included in the calculation of payment rates; 1 or more proposals for the implementation of payment adjustments in counties where the payment rate has been affected due to failure to account for the cost of such services; and a system to ensure that when a Medicare+Choice enrollee receives covered services through a facility of these Departments, there is an appropriate payment recovery to the Medicare program.

Effective Date:

- Upon enactment.

Subtitle B -- Other Medicare+Choice Reforms

Payment of Additional Amounts for New Benefits Covered During a Contract Term (Section 611)

Prior Law:

- Medicare+Choice organizations are required to cover all Medicare-covered services under the Medicare+Choice plans that they offer, including services that become covered as the result of a national coverage determination (NCD). If coverage of additional services required under an NCD would result in significant additional costs for a Medicare+Choice organization, and the costs of these services are not included in Medicare+Choice capitation rates, HCFA pays for the costs of the services under fee-for-service payment rules until the effects of the NCD are taken into account in capitation rates.

Provision:

- The provision expands the current rules that apply to coverage required under an NCD to apply to coverage required to be covered under Part C as the result of a legislative change. Also, it requires that cost projections and payment adjustments be based on actuarial estimates provided by the Chief Actuary of HCFA.

Effective Date:

- Effective for NCDs and legislative changes in benefits occurring on or after enactment.

Restriction on Implementation of Significant New Regulatory Requirements Mid-Year (Section 612)

Prior Law:

- No provision. Contracts between HCFA and Medicare+Choice organizations for 2001 provide that no regulations or policies which create significant new operational costs will become effective prior to January 1, 2002, except where implementation during 2001 is required by statute or in connection with litigation affecting HCFA policies.

Provision:

- The provision would preclude the Secretary from implementing, other than at the beginning of a calendar year, Medicare+Choice regulations that impose new, significant regulatory standards on Medicare+Choice organizations. This provision is limited to the effects of regulations related to Medicare+Choice standards.

Effective Date:

- Upon enactment.

Timely Approval of Marketing Material That Follows Model Marketing Language (Section 613)

Prior Law:

- All Medicare+Choice marketing materials were required to be submitted for review 45 days prior to the intended date of distribution to beneficiaries. Materials were deemed approved if HCFA does not disapprove them within the 45-day period.

Provision:

- This provision reduces the review period to 10 days for marketing materials that use, without modification, model language that has been supplied by HCFA. These materials would also be deemed approved absent a disapproval within the 10-day period.

Effective Date:

- January 1, 2001.

Avoiding Duplicative Regulation (Section 614)

Prior Law:

- The BBA preempts application to Medicare+Choice organizations of State law or regulations related to benefit requirements, requirements relating to inclusion or treatment by providers, and coverage determinations (including related appeals and grievance processes).

Provision:

- This provision expands the preemption on State benefit requirements to include cost-sharing requirements. The provision also expands current preemption to include requirements relating to marketing materials, and summaries and schedules of benefits.

Effective Date:

- Upon enactment.

Election of Uniform Local Coverage Policy for Medicare+Choice Plan Covering Multiple Localities (Section 615)

Prior Law:

- Medicare+Choice plans are required to provide enrollees with those items and services (except for hospice care) that are available to beneficiaries in original Medicare in the area served by the plan. Under the June 29, 2000 final rule, Medicare+Choice plans must follow national coverage determinations, as well as local medical review policies (LMRPs) of contractors in the plan's service area. If the service area includes the jurisdiction of more than one contractor, then the plan must follow the policies of the contractor in effect at the site where the services are provided.

Provision:

- If there are conflicting LMRPs in a Medicare+Choice plan's service area, the organization can apply to all its enrollees, the LMRP that the Secretary identifies as the most beneficial to enrollees.

Effective Date:

- Upon enactment.

Eliminating Health Disparities in Medicare+Choice Program (Section 616)

Prior Law:

- Under the BBA, Medicare+Choice organizations are required to arrange ongoing quality assurance programs for its plans.

Provision:

- This provision expands the Medicare+Choice quality assurance programs for Medicare+Choice plans to include a separate focus on racial and ethnic minorities.

- The Secretary is required to report to Congress not later than 2 years after enactment and biennially thereafter, on the impact of the focus on racial and ethnic minorities within plan quality assurance programs. The reports are to include: a description of the methods used by plans; an evaluation of the impact of the programs on eliminating disparities and improving enrollee satisfaction; and recommendations for ways to reduce clinical outcome disparities.

Effective Date:

- Upon enactment.

Medicare+Choice Program Compatibility with Employer or Union Group Health Plans (Section 617)

Prior Law:

- Medicare+Choice organizations market both to individual enrollees and to employer and union groups. Generally, there are no differences with regard to contractual obligations with HCFA for individual Medicare+Choice enrollees compared with individuals who enroll as part of an employer or union group.

Provision:

- This provision authorizes the Secretary to waive or modify Medicare+Choice requirements that hinder the design of, offering of, or enrollment in, Medicare+Choice plans sponsored by organizations that contract with employers, labor organizations, or trustees of a fund established by employers and/or labor organizations.

Effective Date:

- Effective for years beginning with 2001.

Special Medigap Enrollment Anti-Discrimination Provision for Certain Beneficiaries (Section 618)

Prior Law:

- The BBA created certain new rights for beneficiaries to the guaranteed issue of Medigap policies. Under these provisions, guaranteed issue periods were triggered for certain individuals based on events such as Medicare+Choice contract termination or loss of employer coverage. Guaranteed issue periods generally began upon termination of coverage, or in some cases, disenrollment, and ended 63 days after that date.

- The BBRA included a provision which gave beneficiaries enrolled in terminating Medicare+Choice plans, the option of starting their 63-day guaranteed issue period either when they received notice of their plan's contract termination decision or upon termination of coverage by the M+C plan. If they opt to start the period with the receipt

of the notice, however, they were required to disenroll from the plan before the plan's contract terminated.

- Beneficiaries in a Medicare+Choice 12-month trial period whose plan terminated its contract during the trial period, were subject to termination of their guaranteed issue rights before the end of their trial period.

Provision:

- The provision modifies the guaranteed issue periods as follows:

  -- Involuntary termination of M+C and certain other coverage: For beneficiaries affected by termination of an M+C, PACE, or other managed care plan, or Medicare SELECT policy, the guaranteed issue period starts upon receipt of notice of coverage termination and continues for 63 days after coverage is terminated.

  . -- Voluntary disenrollments: (e.g., for beneficiaries who disenroll before the end of a 12-month trial period) The guaranteed issue period begins 60 days before the effective date of disenrollment and ends 63 days after.

  -- Loss of employer coverage: The guaranteed issue period starts upon receipt of notice of coverage termination or notice of claim denial resulting from the termination, and continues 63 days thereafter.

  -- Insolvent Medigap plan: The guaranteed issue period begins on either the date of receipt of notice of termination or insolvency, or the date coverage ends, and continues 63 days after coverage ends.

  In all other situations, the period would begin on the effective date of disenrollment and end 63 days after such date.

- Beneficiaries in a 12-month trial period (after joining an M+C plan at age 65, or after dropping a prior Medigap policy to enroll in an M+C, PACE, other managed care plan, or Medicare SELECT policy) whose coverage terminates during the trial period, may enroll in another plan or policy and have a full 12-month trial period with that plan. Such enrollment must occur within the 2-year period beginning on the date the beneficiary first enrolled in a plan or policy.

Effective Date:

- Upon enactment.

Restoration of Effective Date of Elections for Medicare+Choice Plan Elections (Section 619)

Prior Law:

- As a result of BBRA, the effective date of beneficiaries' changes in elections of M+C plans became dependent upon the day of the month in which the election was made.

Changes made up to, and including, the 10th of the month became effective in the month following the election. Changes made after the 10th became effective in the second calendar month following the month in which the election was made.

Provision:

- This provision restores the pre-BBRA effective date rules whereby the effective date of an election or change in election is the month following the election, regardless of the day of the month on which the election was made.

Effective Date:

- June 1, 2001.

Permitting ESRD Beneficiaries to Enroll in Another Medicare +Choice Plan if the Plan in Which They are Enrolled is Terminated (Section 620)

Prior Law:

- Beneficiaries with ESRD were prohibited from joining a Medicare+Choice plan, but could remain in one if they developed ESRD while enrolled. In regulations, HCFA interpreted this latter exception to extend to any individual who developed ESRD while enrolled with an organization offering an M+C plan, even if the individual was not enrolled in the organization's Medicare+Choice plan when he or she developed ESRD. Under this interpretation, such an individual could remain enrolled with the organization under a Medicare+Choice plan upon becoming Medicare eligible, or after switching from another plan.

Provision:

- Medicare+Choice enrollees with ESRD are permitted to enroll in another plan, if their plan withdraws or is terminated.

Effective Date:

- Upon enactment, and retroactive to terminations and discontinuations occurring after December 31, 1998, but before the date of enactment.

Providing Choice for Skilled Nursing Facility Services Under the Medicare+Choice Program (Section 621)

Prior Law:

- The right to receive services outside a coordinated care plan's network without an authorization generally is limited to emergency services, post-stabilization services, and certain out-of-area services. The statute outlines the rules by which “non-contract”service providers will be paid if serving beneficiaries enrolled in Medicare+Choice plans.

Provision:

- Medicare+Choice enrollees who are going to receive post-hospital, skilled nursing facility (SNF) services can elect, subject to certain requirements, to receive treatment from: (1) the SNF in which the enrollee resided prior to the hospital admission; (2) a SNF that provides care through a continuing care retirement community in which the enrollee resides; or (3) the SNF in which the spouse of the enrollee is residing at the time of the hospital discharge.

- A Medicare+Choice organization must accept an election if the selected SNF agrees to accept "substantially similar payment" under the same terms and conditions that apply to contracting facilities. The resulting coverage can be no less favorable to the enrollee than would have been provided.

- While the Medicare+Choice organization must accept the election, the provision does not require the desired SNF to accept the enrollee, nor does it prohibit the SNF from imposing conditions on the acceptance of the enrollee.

- MedPAC is required to report within 2 years after the date of enactment on the effects of this provision upon Medicare+Choice organizations, including: how it affects the scope of other benefits provided by the plan; what administrative costs are incurred by the plan; and the contractual relationships between Medicare+Choice organizations and SNFs.

Effective Date:

- Effective for Medicare+Choice contracts entered into or renewed on or after the date of enactment.

Providing for Accountability of Medicare+Choice Plans (Section 622)

Prior Law:

- The Secretary is required to review the adjusted community rates (ACRs), the amounts of the basic and supplemental premiums, the actuarial value of additional benefits and the value of deductibles, coinsurance, and copayments. There is no provision for review by the HCFA Chief Actuary.

Provision:

- The provision requires the HCFA Chief Actuary to determine the appropriateness of assumptions and data used by M+C organizations with respect to ACRs, the amounts of the basic and supplemental premiums, the actuarial value of additional benefits and the value of deductibles, coinsurance, and copayments.

Effective Date:

- Applies to ACR submissions filed on or after May 1, 2001.

Increased Civil Money Penalty for Medicare+Choice Organizations That Terminate Contracts Mid-Year (Section 623)

Prior Law:

- The BBA included general language providing for civil money penalties when an M+C organization fails "substantially to carry out" its contract. This penalty can be applied in situations where an M+C organization terminates its contract mid-year, but the civil money penalty is limited to $25,000.

Provision:

- This provision establishes a civil money penalty of not more than $100,000 (or such higher level as the Secretary establishes in regulation) if the Secretary's finding of an organization's substantial failure to carry out its contract is based on the organization terminating its contract other than as provided in law and regulations.

Effective Date:

- Effective for terminations occurring after enactment.

Subtitle C -- Other Managed Care Reforms

One-Year Extension of Social Health Maintenance Organization (SHMO) Demonstration Project (Section 631)

Prior Law:

- The SHMO demonstration was to expire 18 months after Secretary submits report with a plan for integration and transition of SHMOs into an option under the M+C program.

Provision:

- This provision extends the expiration date by 1 year, to 30 months after the Secretary submits the mandated report.

Effective Date:

- Upon enactment.

Revised Terms and Conditions for Extension of Medicare Community Nursing Organization (CNO) Demonstration Project (Section 632)

Prior Law:

- The BBRA extended the CNO demonstration from the end of 1999 to the end of 2001. During the 2-year extension period, the Secretary was required under the BBRA to reduce the capitated payments to the CNOs so that they are budget neutral relative to expenditures in the absence of the demonstration. The Secretary was also to report by July 1, 2001 on the results of the demonstration and to include in the report a description of data collected that is relevant to analyzing the results of the project.

Provision:

- The provision eliminates the requirement that CNO capitated payments be reduced to ensure budget neutrality and instead provides for the following:.

-- From January, 2000 through September, 2000, the projects are to operate under the same terms and conditions as were applicable during 1999.

-- From October, 2000 through December, 2000, the CNOs will receive a capitated payment equal to the 1999 rate, adjusted for inflation, utilization, and for changes in service packages, but reduced by 10 percent for projects in Arizona, Minnesota, and Illinois and by 15 percent for the project in New York. The case management fee will be 1999 fee updated for inflation.

-- For 2001, the October to December, 2000 rate will be updated for inflation, utilization, and changes in service packages. The case management fee for the same period will be updated for inflation.

-- Beginning October 1, 2000, the case management fee is to be paid only for specified frail enrollees. In addition, greater uniformity in clinical features among participating sites and the implementation of satisfaction surveys and reporting on quality indicators is required..

- By July 1, 2001, the Secretary is to submit to the House Committees on Ways and Means and Commerce, and to the Senate Committee on Finance, a preliminary report evaluating the projects for the period July, 1997 through December, 1999 and for the extension period after September 30, 2000. A final report is due by July 1, 2002 for the period after December 31, 1999. The provision would require certain methods to be used to compare spending per beneficiary under the projects.

Effective Date:

- Effective as if enacted in the BBRA.

Extension of Medicare Municipal Health Services Demonstration Projects (Section 633)

Prior Law:

- The BBA authorized the Secretary to extend the Municipal Health Services Project (MHSP) demonstration through December 31, 2000, for individuals already enrolled in the project who had received at least 1 project service between January 1, 1996, and enactment of the BBA. The BBRA further extended the demonstration through December 31, 2002.

Provision:

- The provision extends the MHSP demonstration through December 31, 2004.

Effective Date:

- Upon enactment.

Service Area Expansion for Medicare Cost Contracts During Transition Period (Section 634)

Prior Law:

- Entities eligible to enter into or renew cost contracts under section 1876 of the Social Security Act are limited to those that had either a cost contract or a Health Care Prepayment Plan agreement on August 5, 1997, the date of the BBA's enactment. This provision effectively precluded service area expansions for entities with cost contracts. No such contracts can be extended or renewed after December 31, 2004.

Provision:

- The provision allows service area expansions for Medicare cost contracts, if the request is submitted to the Secretary before September 1, 2003. It retains the December 31, 2004 sunset.

Effective Date:

- Upon enactment.

TITLE VII -- MEDICAID

Disproportionate Share Hospital (DSH) Payments (Section 701)

Modifications to DSH Allotments (Section 701(a))

Prior Law:

- The Balanced Budget Act of 1997 set specific dollar limits on the amount of Federal matching funds that States could receive for making payment adjustments to hospitals that serve a disproportionate share of Medicaid or low-income patients. For Federal fiscal years 1998 through 2002, the dollar amount for each State is listed in a table in the statute. For many States, the dollar amounts in the table decrease over the 5-year period; for other States the dollar amounts remain fixed over the 5-year period. For fiscal years 2003 and beyond, the amounts are updated by the CPI-U, except that there is no increase if a State's DSH program exceeds 12 percent of its total medical assistance payments. The Balanced Budget Refinement Act of 1998 made small adjustments to the dollar amounts for a number of States and for the District of Columbia.

Provision:

- This provision increases the BBA DSH allotments to States for FYs 2001 and 2002. For FY 2001, the allotment is the FY 2000 allotment increased by the CPI-U (instead of the same or lower amount as prior years pursuant to the table). The FY 2002 allotment is the FY 2001 allotment increased by CPI-U. Both the FY 2001 and the FY 2002 allotments remain subject to the provision that limits or prohibits an increase over the prior year's allotment if the State DSH program exceeds 12 percent of its total medical assistance payments in that year. For FY 2003, allotments to States would revert to the amount listed in the statutory table for FY 2002, increased by the CPI-U.

- The provision also includes an increase in allotments for States whose BBA DSH spending is less than 1 percent of their total Medicaid program spending. For those

States, the FY 2001 allotment is equal to 1 percent of the State's FY 99 total Medicaid expenditures as reported to HCFA on August 31, 2000. For each succeeding fiscal year, the allotments to these States would be increased by the CPI-U, up to 12 percent of the State total medical assistance expenditures for that year.

Effective Date:

- These provisions became effective when the Final Rule on the upper payment limit (UPL) was published in the Federal Register. That rule was published on January 12, 2001.

Assuring the Identification of Medicaid Managed Care Patients (Section 701(b))

Prior Law:

- The statute is silent on how managed care days and capitation payments are to be considered in States' DSH programs.

Provision:

- This provision requires Medicaid managed care organizations' (MCO) contractors to provide information that allows the State to determine which hospital services are provided to Medicaid beneficiaries through managed care, or include a sponsorship code on the beneficiary's identification card for the contractor so the hospital will know the patient is a Medicaid patient.

- The provision would clarify that Medicaid managed care and primary care case management enrollees are to be included for the purposes of calculating the Medicaid inpatient utilization rate and the low-income utilization rate and must be taken into account when developing the State's DSH payment methodology.

Effective Date:

- January 1, 2001.

Application of DSH Transition Rule to Public Hospitals in all States (Section 701(c))

Prior Law:

- The Omnibus Budget Reconciliation Act of 1993 established caps on the amount of DSH payments States could make to each hospital. After a 2-year transition, the cap was equal to 100 percent of the hospital's costs for treating unisured patients and the shortfall for treating Medicaid patients. The BBA extended a transition period for California public hospitals at 175 percent of hospital costs through State Fiscal Year 2000 and the BBRA made this provision permanent for California.

Provision:

- This provision allows all States to pay qualifying public hospitals DSH payments up to 175 percent of their unreimbursed costs for treating uninsured or Medicaid patients for 2

SFYs (beginning the first day of the first State fiscal year that begins after September 30, 2002 and ends on the last day of the next SFY). Unlike the previous DSH transition rule, any public DSH hospital is eligible, not just those that serve a very high number of Medicaid or low-income patients. California is exempted from the 2-year time limitation and may expand the 175 percent rule to all DSH hospitals, rather than only those with high Medicaid utilization. This subsection also includes baseline adjustments for 1115 waivers due to the increased payments for public hospitals resulting from this provision.

Effective Date:

- The first day of the State fiscal year that begins after September 30, 2002.

Assistance for Certain Public Hospitals (Section 701(d))

Prior Law:

- No provision.

Provision:

- This provision permits States to make additional Medicaid payments that are not DSH payments, to certain public hospitals that: are owned or operated by a State (or by an instrumentality or unit of government within a State); were not receiving DSH payments as of October 1, 2000; and had a low-income utilization rate in excess of 65 percent as of the same date. The Federal share of such payments for all States cannot exceed the following amounts: $15 million for FY 2002; $176 million for 2003; $269 million for 2004; $330 million for 2005; and for FY 2006 and each fiscal year thereafter; $375 million.

Effective Date:

- Payments can be claimed starting in Federal fiscal year 2002.

DSH Payment Accountability Standards (Section 701(e))

Prior Law:

- The statute requires the Secretary to collect information on State DSH payment methodologies and payments to DSH hospitals, as well as the type of hospitals that receive DSH payments (public, private, profit, non-profit).

Provision:

- This provision requires the Secretary to implement accountability standards to ensure that DSH payments are used to reimburse States and hospitals that are eligible for such payments for providing uncompensated health care to low-income patients and are otherwise in accordance with Medicaid statutory requirements.

Effective Date:

- The new standards must be implemented no later than September 30, 2002.

New Prospective Payment System for FQHCs and RHCs (Section 702)

Prior Law:

- The BBA established a phase-out of cost-based reimbursement requirements for FQHCs over a 5-year period (starting in FY 2000: 95 percent, 90 percent, 85 percent, 70 percent, then elimination). The BBRA slowed this phase-out (starting in FY 2001 (95 percent, 90 percent, 85 percent, then elimination). The BBRA also called for a GAO study to look at the impact of the elimination of cost-based reimbursement and to make recommendations for a new payment system.

Provision:

- The provision replaces the phase-out of cost-based reimbursement to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) with requirements for a new prospective payment system (PPS). The PPS system will establish base-year costs for all FQHCs and RHCs and inflate the base-year costs each year by the Medicare Economic Index (MEI). New centers and clinics will use either an average of costs of other clinics in the area or, in the absence of such other clinics, a Secretarial-approved method to calculate their base-year costs. States are given the flexibility to establish alternative payment systems for these centers and clinics as long as the alternative system is agreed to by both the State and the FQHC/RHCs and does not result in payments that would be less than those that would have been received under the PPS system.

- The provision calls for a GAO study on the need for rebasing clinic costs and a methodology for doing so 4 years after enactment.

- There is also a provision that prohibits the new payment system from being waived under a Medicaid 1915(b) waiver. This parallels the prohibition that was included under the old cost-based payment system in effect prior to the enactment of the BBA.

Effective Date:

- The new payment provision is effective for all payments made on or after January, 1, 2001.

Streamlined Approval of Continued State-wide Section 1115 Medicaid Waivers (Section 703)

Prior Law:

- There is no prior statutory provision that addresses continuations for section 1115 demonstration waivers that have already received an initial 3-year extension. The BBA established the process for States with section 1115 demonstrations to request a 3-year extension.

Provision:

- This provision establishes an expedited approval process for submitting requests for, and receiving continuations of, Medicaid demonstration waivers authorized under Section 1115, which have already received initial 3-year extensions. The provision specifies a process and time frame for submission of the continuation request and a process and time frame for HHS review of the request, which includes specifications for changing the terms and conditions of the waiver project (not permitted in the BBA provision). The State must submit the continuation request at least 120 days prior to the expiration of the current period of the waiver project (compared to 12 to 18 months in the BBA provision). The Secretary then has 45 days to indicate whether the terms and conditions will be subject to review, or the continuation request will be deemed approved. Not later than 45 days after notifying the State of a review, the Secretary must inform the State of proposed new terms and conditions or the continuation request will be deemed approved. A 30-day period for negotiation of revised terms and conditions follows. Within 120 days of the original submission, or a later date that has been agreed to by the chief executive officer of the State, the Secretary is required to approve or disapprove the continuation request. Approval may be either with modifications to the terms and conditions that were mutually agreed upon or, in the absence of an agreement, with modifications determined by the Secretary to be reasonable, consistent with overall project objectives, and consistent with the law. If the Secretary does not approve or disapprove the continuation request on a timely basis, it would be deemed approved with the terms and conditions modified only to the extent agree to (if any) by the Secretary and the State. Approvals would be for periods not to exceed 3 years, and would be subject to the final reporting and evaluation requirements in current law.

Effective Date:

- Applies to requests for extensions pending or submitted on or after the date of enactment.

Medicaid County-Organized Health Systems (Section 704)

Prior Law:

- COBRA, as amended by OBRA 1990, established county-operated health insuring organizations in the State of California and set a limit such that these HIOs could enroll no more than 10 percent of Medicaid beneficiaries in the State. The HIOs are exempt from certain Federal Medicaid HMO contracting requirements, but are subject to State HMO requirements.

Provision:

- The provision increases the HIO enrollment rate described above from 10 percent to 14 percent.

Effective Date:

- Upon enactment.

Deadline for Issuance of Final Regulation Relating to Medicaid Upper Payment Limits (Section 705)

Prior Law:

- No provision.

Provision:

- The provision directs the Secretary to issue a final rule on Medicaid Upper Payment Limits (UPL) by December 31, 2000, based on the prior Notice of Proposed Rulemaking, and waives the requirements of the Administrative Procedures Act to facilitate the publication. The final rule must modify the upper payment limit test applied to State-owned and non-State government-owned hospitals, nursing homes, clinics and intermediate care facilities for the mentally retarded. The final rule must also provide a transition period for States with UPL amendments that were effective or approved by HHS before October 1, 1992. That transition period must provide a decrease in payments that would exceed the UPL test by 15 percent each year from September 30, 2002 through September 30, 2002.

Effective Date:

- Upon enactment.

Alaska FMAP (Section 706)

Prior Law:

- The BBA legislatively raised the Federal Medical Assistance Percentage (FMAP) for Alaska to 59.8 percent for payments for Medicaid and SCHIP services furnished during fiscal years 1998, 1999, and 2000.

Provision:

- This provision effectively retains the 59.8 percent match rate for fiscal years 2001 through 2005.

Effective Date:

- October 1, 2000.

1-Year Extension of Welfare-to-Work Transition (Section 707)

Prior Law:

- States are required to provide up to 1 year of continued Medicaid for families in transition from welfare to work. This authority was to expire at the end of fiscal year 2001.

Provision:

- The provision extends Welfare-to-Work transitional coverage through fiscal year 2002.

Effective Date:

- Upon enactment.

Additional Entities Qualified to Determine Medicaid Presumptive Eligibility for Low-Income Children (Section 708)

Prior Law:

- The BBA permitted States to elect to enroll children in Medicaid for a limited period before full Medicaid applications are filed and processed, based on a determination of likely Medicaid eligibility made by a qualified entity. Qualified entities were those determined by the State to be capable, and either eligible for payments for items and services under the State plan, or that determined eligibility under certain other programs, such as WIC and Head Start. Presumptive eligibility lasts only up to 2 months, after which continuing coverage depends on a full Medicaid application being filed and a full determination being made by the State.

Provision:

- The provision expands the list of possible qualified entities that States may authorize to perform presumptive eligibility determinations to include schools, homeless shelters, certain housing programs, certain Native American-run programs, or any other entity deemed by the State to be capable of making the determination.

Effective Date:

- Upon enactment.

Development of Uniform QMB/SLMB Application Form (Section 709)

Prior Law:

- States are required to pay Medicare cost-sharing for certain groups of low-income Medicare beneficiaries. (Qualified Medicare beneficiaries (QMBs) have incomes below the Federal poverty level and assets below a specified level. Medicaid pays their Medicare premiums, deductibles, and coinsurance.) Specified low-income Medicare beneficiaries (SLMBs) resemble QMBs except their income is between 100 and 120 percent of poverty.) States determine how they will administer eligibility for this benefit.

Provision:

- In consultation with beneficiary groups and States, the Secretary must develop a simplified, easy-to-read application form to be shared with States for their use in the QMB/SLMB application process.

Effective Date:

- One year after enactment.

Technical Correction (Section 710)

Prior Law:

- Congress authorized Medicaid eligibility for 2 groups with higher incomes than the typical Medicaid income level: persons aging-out of foster care and certain uninsured, vulnerable women diagnosed with breast or cervical cancer under a program funded by the Centers for Disease Control. However, income restrictions in the law governing Federal matching resulted in an unintended cap on income.

Provision:

- The technical correction removes the unintended income cap and allows Medicaid for all persons in the 2 authorized eligibility categories.

Effective Date:

- As if enacted in the original authorizing laws.

TITLE VIII -- STATE CHILDREN'S HEALTH INSURANCE PROGRAM

Special Rule for Redistribution and Availability of Unused FY 1998 and 1999 SCHIP Allotments (Section 801)

Prior Law:

- SCHIP allotments to States are available for expenditure for 3 fiscal years; the fiscal year in which it was allotted and the following 2 fiscal years. The FY 1998 allotments expired on September 30, 2000. Any FY 1998 funds remaining unspent after that date are redistributed to States that fully expended their entire FY 1998 SCHIP allotments within the 3-year period of availability. The methodology for redistributing the unspent funds to the States that fully expended their allotments is to be determined by the Secretary. The funds redistributed to States would be available for 1 year. Any money left unspent at that time would revert to the Treasury. Under current law, all administrative, outreach, and direct provision of services costs are capped at 10 percent of program expenditures.

Provision:

- This provision establishes a new method for redistributing unspent FY 1998 and FY 1999 SCHIP allotments. States that fully expended their FY 1998 allotments will receive a redistribution equal to the amount of their total SCHIP expenditures for FY 1998, 1999, and 2000, minus the amount of their FY 1998 allotment. Each territory that expends its allotment receives an amount that bears the same ration to 1.05 percent of the total amount available for redistribution as the ratio of its original allotment to the total allotment for all territories. States that have not expended their FY 1998 allotments can retain a portion of these funds. The amount of funds retained is the total amount of unspent funds, less the amounts distributed to the States and territories that fully expended their allotments, multiplied by the ratio of a State's unspent original allotment to the total amount of unspent funds. The same process for redistribution will also apply to the FY 1999 allotments.

- The FY 1998 and FY 1999 allotments will remain available for States until FY 2002. The Secretary is directed to use amounts reported by the States not later than December 15, 2000 for the FY 1998 redistribution and November 30, 2001 for the FY 1999 allotments. States that retain unspent funds will also be allowed to use up to 10 percent of the retained money for outreach for the 2-year period of availability.

Effective Date:

- Upon enactment.

Authority to Pay Medicaid Expansion Costs from Title XXI Appropriation (Section 802)

Prior Law:

- States can set up their SCHIP programs as a Medicaid expansion, as a separate State program, or a combination of both. Currently, the title XXI statute does not provide for a transfer of funds from title XXI appropriations to title XIX appropriations. States that do a Medicaid expansion or a combination program use regular title XIX grant awards and their title XXI allotments are simply "reduced" by the amount of money spent under the title XXI Medicaid expansions.

Provision:

- Section 2104(d) allows States that have Medicaid expansions under Title XXI to actually draw down funds from the Title XXI appropriation and allows HHS to make a retroactive adjustment to the title XIX and XXI accounts to charge title XXI accounts and offset Medicaid accounts for Federal matching for a title XXI-related Medicaid expansion. This will eliminate any problem of double appropriations and bookkeeping.

Effective Date:

- Effective as if included in the BBA.

Addition of Explicit Authority to do Presumptive Eligibility in SCHIP (Section 803)

Prior Law:

- There is no explicit authority to do presumptive eligibility in a non-Medicaid title XXI program. Some States have crafted presumptive eligibility programs by paying the costs for children who were eventually determined to be ineligible for both SCHIP and Medicaid, out of the 10 percent portion of the allotments that is allowed to be used for administrative costs, outreach costs, and other health program costs.

Provision:

- This provision provides explicit authority to conduct presumptive eligibility programs in SCHIP.

Effective Date:

- Upon enactment.

TITLE IX -- OTHER PROVISIONS

Subtitle A -- PACE Program

Extension of Transition for Current Waivers (Section 901)

Prior Law:

- OBRA 1986 required the Secretary to grant waivers of certain Medicare and Medicaid requirements to not more than 10 public or non-profit private community-based organizations to provide health and long-term care services on a capitated basis (known as the Program of All-Inclusive Care for the Elderly, or PACE) to frail elderly persons at risk of institutionalization. OBRA 1990 expanded the number of organizations eligible for such waivers to 15.

- The Balanced Budget Act of 1997 established PACE as a permanent provider type under Medicare and as an optional benefit under Medicaid. The PACE waiver authority was to be repealed and waivered programs were to transition to permanent provider status. Transition periods would be permitted for PACE programs, with waivers granted before the initial effective date of the interim final PACE regulations. The transition period could last up to 24 months, but State Medicaid agencies could elect to continue such PACE waiver programs for up to 3 years after that date, as long as the programs continued to operate under the waiver's terms and conditions.

Provision:

- The transition periods are extended for up to 36 months, with a State option for up to 4 years.

Effective Date:

- None specified; assumed to be enactment.

Continuing of Certain Operating Arrangements Permitted (Section 902)

Prior Law:

- No provision.

Provision:

- This provision specifies that if a PACE demonstration program has not yet become a permanent provider and has contractual or other operating arrangements not otherwise recognized in the PACE regulations, but which were in effect on July 1, 2000, the Secretary (in close consultation and with the concurrence of the State administering agency) must grandfather these arrangements and permit them to continue, as long as the Secretary and State find them to be reasonably consistent with the objectives of the PACE program.

Effective Date:

- As if included in the Balanced Budget Act of 1997 (enacted August 5, 1997).

Flexibility in Exercising Waiver Authority (Section 903)

Prior Law:

- When PACE was enacted as a permanent program in the BBA in 1997, the Secretary (in close consultation with State administering agencies) was authorized (within certain conditions and limitations) to modify or waive provisions of the PACE protocol in order to provide for reasonable flexibility in adapting the PACE service delivery model to the needs of particular organizations (such as those in rural areas or those that may determine it appropriate to use non-staff physicians, according to State licensing law requirements).

- In the interim final PACE regulations, HCFA chose in this early phase to limit exercise of Secretarial flexibility to circumstances close to those outlined in the statutory language.

Provision:

- This provision requires the Secretary to approve or deny a request for a modification or waiver of the PACE protocol not later than 90 days after receiving the request. The law now also indicates that the Secretary may modify or waive provisions of the PACE protocol in a manner that responds promptly to the needs of PACE programs relating to areas of employment and use of community-based primary care physicians.

Effective Date:

- None specified; assumed to be enactment.

Subtitle B -- Outreach to Eligible Low-Income Medicare Beneficiaries

Outreach on Availability of Medicare Cost-Sharing Assistance to Eligible Low-Income Medicare Beneficiaries (Section 911)

Prior Law:

- The Social Security Administration, HCFA and States collaborate to identify and enroll beneficiaries in Medicaid and Medicare, as appropriate, and properly collect Medicare premium payments.

Provision:

- The SSA Commissioner is required to identify potentially eligible QMB/SLMBs and notify them about the availability of such Medicaid assistance. SSA must share this information with States, and update it at least yearly.

- GAO must study this requirement and report to Congress within 18 months after the outreach program begins on the impact of this outreach on QMB/SLMB enrollment.

Effective Date:

- One year after enactment.

Subtitle C -- Maternal and Child Health Block Grant

This provision is not related to HCFA.

Subtitle D -- Diabetes

Increase in Appropriations for Special Diabetes Programs for Type I Diabetes and Indians (Section 931)

Prior Law:

- The Balanced Budget Act of 1997 established special grant programs in the Public Health Service Act for prevention and treatment of Type I diabetes in children and in Indians. Funding of $30 million per year for FY 1998 to FY 2002 was authorized and appropriations transferred from amounts appropriated elsewhere in the BBA for SCHIP. The BBA required the Secretary to conduct an evaluation of the new diabetes grant programs and to submit a final report to the Congress on the evaluation not later than January 1, 2002.

Provisions:

- This provision includes an additional $70 million per year from general revenues, to be added to the $30 million per year from SCHIP, for each program for FY 2001 and FY 2002. The provision adds $100 million of new general revenues for each program for FY 2003. The date for the final report to Congress on evaluation of the programs is delayed for 1 year, to January 1, 2003.

Effective Date:

- None specified; assumed to be enactment.

Subtitle E -- Information on Nursing Facility Staffing

Posting of Information on Nursing Facility Staffing (Section 941)

Prior Law:

- No provision.

Provision:

- This provision requires that nursing homes post in a clearly-visible place, the current numbers of licensed and unlicensed nursing staff directly responsible for resident care in

the facility, daily, for each shift, in a uniform manner specified by the Secretary and that nursing homes make this same data available to the public upon request.

Effective Date:

- January 1, 2003.

P. L. 106-354 BREAST AND CERVICAL CANCER PREVENTION AND TREATMENT ACT OF 2000

Optional Medicaid Coverage of Certain Breast or Cervical Cancer Patients

Prior Law:

- Women who have low incomes and are uninsured or underinsured may receive screening and diagnostic services for breast and cervical cancer under the National Breast and Cervical Cancer Early Detection Program (NBCCEDP), which is funded by the Centers for Disease Control (CDC) and implemented by States. The legislation does not define "low-income" but CDC has administratively defined the level to which States must target their CDC funds as 250 percent of poverty or less.

- CDC funds must not be used to pay for treatment services for women that the program has determined need treatment for such cancers. Providers under the program are required to arrange for treatment services but, lacking access to any predictable or sustainable payment source, their ability to comply with this requirement -- and access to care for women needing treatment -- is severely challenged.

Provision:

- States have the option to provide Medicaid to women screened by the CDC program and found to need treatment. To qualify, the women must be otherwise ineligible for Medicaid, not have creditable coverage (as defined under Section 2701(c) of the Public Health Service Act), and be under age 65. Eligibility is limited to services provided during the period in which the woman requires treatment for breast or cervical cancer.

- States receive Federal matching payments for Medicaid services to such women at the same enhanced matching rate that they receive for their State Child Health Insurance Program (SCHIP).

Presumptive Eligibility for Certain Breast or Cervical Cancer Patients

Prior Law:

- No provision for women screened by the CDC program. Authority for presumptive eligibility is limited to pregnant women and children. Presumptive eligibility allows States to permit qualified entities to authorize up to 60 days of Medicaid eligibility immediately, based on preliminary information. Qualified entities are providers of Medicaid or certain other services which have been designated by the State to perform

such determinations and which comply with procedural rules. Longer-range eligibility is contingent on the presumptively-eligible individuals filing a full application and being determined by the State to meet all eligibility criteria. During the presumptively-eligible period, Medicaid pays for all Medicaid-covered services provided by any provider that participates in Medicaid.

Provision:

- States have the option to use presumptive eligibility for women covered under the new eligibility option. States receive an enhanced match for services provided in the presumptive period.

Effective Date:

- October 1, 2000.

P. L. 106-310 CHILDREN'S HEALTH ACT OF 2000

Requirement Relating to the Rights of Residents of Certain Facilities (Section 3207)

Prior Law:

- No provision.

Provision:

- Two new parts are added to Title V of the Public Health Service Act. Part H sets a national standard prohibiting the use of restraints (including chemical restraints) or involuntary seclusion imposed for the purpose of discipline or convenience in all health care facilities supported in whole or in part with Federal funds. Restraints and seclusion may only be imposed to ensure the physical safety of the resident or staff member and only under the written order of a physician or other licensed practitioner who is permitted to do so by the State. Federal or State laws which impose greater protections are not preempted.

- In order to continue to receive Federal funding, facilities covered by the Protection and Advocacy for Mentally Ill Individuals Act of 1986 are subject to additional reporting and training requirements. These facilities are required to report deaths that occur while a patient is in restraints or seclusion, or, within 24 hours, of a patient being in restraints or seclusion, or when it can be assumed that the death is a result of restraints or seclusion. These same facilities also must assure an adequate number of personnel to complete evaluations and treatment plans for residents. The staff of such facilities must be trained in the use of restraints and seclusion and that there is a complete and accurate notification of deaths.

- Additionally, Part I imposes similar prohibitions on the use of restraints and seclusion in non-medical community-based facilities for children and youth, including residential treatment facilities. These prohibitions include the use of only trained personnel to impose restraints.

Effective Date:

- Upon enactment.

P.L. 106-417 ALASKA NATIVE AND AMERICAN INDIAN

DIRECT REIMBURSEMENT ACT

Direct Billing of Medicare, Medicaid, and Other Third Party Payors

Prior Law:

- Hospitals and clinics owned or leased by the Indian Health Service (IHS), whether operated by IHS or by Indian Tribes or Tribal organizations were required to send bills to Medicare and Medicaid and to receive payments through a complex and time-consuming series of administrative steps known collectively as "the Secretary's Special Fund." (Tribally owned and operated clinics do not use the Special Fund process. They bill and receive payments on the same basis as other Medicare and Medicaid providers.) Medicare and Medicaid payments in the Special Fund must be spent *exclusively* for making improvements in the IHS facilities necessary to meet accreditation and other Medicare and Medicaid conditions and requirements.

- Beginning in 1990, Congress established a demonstration program authorizing four Tribes operating IHS facilities under self-governance to directly bill Medicare carriers/fiscal intermediaries, to directly bill under Medicaid State plan procedures, and to receive payments back directly from these sources, without going through the Special Fund, similar to other Medicare and Medicaid providers. Medicare and Medicaid payments to the demonstration sites were required to be used *first* (rather than exclusively) for making improvements in the facility necessary to achieve or maintain compliance with Medicare and Medicaid conditions and requirements. Any funds remaining after expenditures necessary for compliance were then to be used for improving the health status of the Tribe (in accordance with IHS requirements). A Report to Congress on the demonstrations indicated that they were achieving greater efficiency, continuing to assure quality care, and allowing more flexibility in using funds to meet pressing health care needs.

Provision:

- These provisions modify the Indian Health Care Improvement Act (IHCIA) and require the Secretary to establish a permanent program and extend it as an option to any Indian Tribe, Tribal organization, and Alaska Native health organization that operates an IHS-owned or-leased hospital or clinic under Tribal self-governance.

    -- As under the demonstrations, Tribes and organizations opting out of the Special Fund process would directly bill the Medicare carrier/fiscal intermediary, bill under a Medicaid State plan, and can now bill any other third party payor, and

would receive payments directly from these sources. These provisions do *not* authorize Tribes to bill HCFA directly, rather than State Medicaid agencies and/or State Medicaid agencies directly ,rather than managed care organizations established under the Medicaid State plan. IHS owned/leased hospitals and clinics directly operated by IHS must still bill and receive payments through the Special Fund. Tribally-owned and-operated clinics *not* leased by IHS continue, as before, to bill and receive payments like other providers, without going through, or having to opt out, of the Special Fund procedures.

-- As under the demonstrations, Medicaid payments directly received by Tribes under this option are to be used first for making improvements in the facility necessary to achieve or maintain compliance with Medicare and Medicaid conditions and requirements. Any funds remaining after expenditures necessary for compliance are then to be used solely for improving the health status of the Tribe (in accordance with IHS requirements).

-- The 4 demonstration programs are grandfathered (deemed approved) to participate in the new program. Other Tribes and organizations that want to opt out of the Special Fund must submit an application to the Secretary, establishing that it meets specified requirements. The Secretary has 90 days to review and approve an application. Approval of applicants and deemed approval of grandfathered demonstration programs continues as long as the entity continues to meet the requirements.

-- IHS and HCFA are to examine on an ongoing basis and implement any administrative changes necessary to facilitate direct billing and payment, including any agreements with States for direct billing under Medicaid, and to enable programs opting out of the Special Fund to provide IHS with medical record information consistent with IHS's medical record system.

-- Programs that have opted out of the Special Fund may reverse the process and opt back in under the same conditions that a Tribe or Tribal organization may decide to take over operation of a program from IHS under self-governance and then reverse that process.

Effective Date:

- October 1, 2000.

P.L. 106-505 Public Health Infrastructure Improvement Act

Organ Procurement Organization Certification (Section 701)

Prior Law:

- HCFA currently recertifies OPOs every 2 years (BBA gave HCFA authority to move to 4-year cycles, based on past performance). Generally, OPOs must meet 75 percent of the national mean of 4 out of 5 performance criteria.

Provision:

- The provision leaves in place OPOs certified as of January 1, 2000 until January 1, 2002, or until new regulations are promulgated. It requires the Secretary to write new regulations by January 1, 2002 that establish a 4-year certification cycle, use multiple outcome measures as part of the certification process, and allow OPOs to appeal a decertification to the Secretary. The newly-promulgated performance standards must rely on outcome and process performance measures that are based on empirical evidence, obtained through reasonable efforts of organ donor potential and other related factors in each service area of qualified OPOs.

Effective Date:

- Upon enactment.

P. L. 106-398 FLOYD D. SPENCE NATIONAL DEFENSE AUTHORIZATION ACT FOR FISCAL YEAR 2001

TITLE VII - HEALTH CARE PROVISIONS

Subtitle B -- Senior Health Care

Implementation of Tricare Senior Pharmacy Program (Section 711), Conditions For Eligibility for Champus and Tricare upon the Attainment of Age 65, Expansion and Modification Of Medicare Subvention Project (Section 712), Accrual Funding for Health Care for Medicare-Eligible Retirees and Dependents (Section 713)

Prior Law:

- In certain instances, military retirees' and their dependents' eligibility for the Civilian Health and Medical Program (CHAMPUS) program (also known as "Tricare standard") ends when such individuals become eligible for Medicare.

Provision:

- Pharmacy benefit: Allows Medicare-eligible military retirees and their dependents to continue to utilize the Department of Defense's pharmacy program.

- Tricare, as second payer benefit: Eliminates the end of CHAMPUS benefits. Allows military retirees and their dependents to continue to be eligible for the Civilian Health and Medical Program (CHAMPUS) as a supplemental benefit to Medicare. For those 65 as of October 1, 2001, they must be eligible for Part A of Medicare. For those not yet 65 as of October 1, 2001, they must be both eligible for Medicare Part A and enrolled in Medicare Part B.

- Extension of subvention demonstration: Extends through 2001 the Senior Prime demonstration program currently being conducted by the Department of Defense and the Department of Health and Human Services. The Secretaries of each respective department may continue the demonstration project if they enter into a new or revised

agreement.

- Establishment of health care fund: Establishes a fund in the Treasury to finance, on an actuarially-sound basis, new benefits granted to Medicare-eligible beneficiaries.

Effective Date:

- April 1, 2001 for the pharmacy benefit.
- October 1, 2001 for the Tricare as second payer benefit.